SERFF Tracking Number: LFSC-126136721 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

Filing at a Glance

Company: LifeSecure Insurance Company

Product Name: Multi-Life Application Filing TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form/Rate

SERFF Tr Num: LFSC-126136721 State: ArkansasLH SERFF Status: Closed State Tr Num: 42479

Co Tr Num: State Status: Approved-Closed Co Status: Reviewer(s): Harris Shearer Authors: Sue Howard, Judy Lucas Disposition Date: 06/12/2009 Date Submitted: 05/26/2009 Disposition Status: Approved-

Group Market Type:

Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized

Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:

Explanation for Combination/Other:

Submission Type: New Submission

Market Type: Individual
Group Market Size:

Overall Rate Impact:

Filing Status Changed: 06/12/2009 Explanation for Other Group Market Type:

State Status Changed: 06/12/2009

Deemer Date: Corresponding Filing Tracking Number: Filing Description:

Re: LifeSecure Insurance Company, NAIC #77720

Form LS-0204 ST 08/09

Multi-Life Applications - Form LS-0204A ST 08/09

Form LS-0205 ST 08/09

Form LS-0051 ST 08/09

SERFF Tracking Number: LFSC-126136721 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number:

Enclosed for your review and approval is our new Multi-Life Applications. These applications will be used with our Long Term Care Insurance Policy (Form # LS-0002 ST 07/07) previously approved for use in your state on 09/10/2007. These applications are new and will not replace any forms currently approved in your state

These applications are designed to be used as either a simplified issue application (completing limited sections of the application) or if they do not qualify based on the criteria (amount of Benefit Bank chosen, age of the proposed insured and if they are applying during the enrollment period and meet the definition of actively at work), then completing the full application. All coverage is individually underwritten and all applicants will be issued a the policy at Multi-Life rate class as detailed in the Actuarial Addendum

There are 3 applications for your review..

Form LS-0204A ST 08/09 is the paper application. This application will be used by licensed agents appointed by our company either in person or via the phone. If the agent is taking the application over the phone, the agent will mail the completed application to the insured with all of the required forms and disclosures for review and signature.

Form LS-0204 ST 08/09 is an agent sold electronic application. This application will be used by agents to take an application online and submit electronically using a voice authorization. This is the same process used in our agent sold online application previously approved by your department.

The PDF output of this electronic application is also submitted. This document has the same form number and is being sent to reflect the actual printed version of the online application that will be generated and included with the approved policy documents.

Form LS-0205 ST 08/09 is a self-serve electronic application. This application will be used by applicants to enter their information and submit electronically using an "I accept" button electronic signature. This application will be done after a presentation to the employer group or an association by one of our licensed agents.

The agent will be available to assist with this process or for questions. All required disclosures and documents will be available to the proposed insured either electronically (linked through the application or via paper by the agent if the insured prefers.). The PDF of this version is also enclosed as the end result document that will be issued and sent to the insured with their approved policy.

SERFF Tracking Number: LFSC-126136721 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number:

We are also submitting our revised Schedule of Benefits. This document has been revised to reflect the new rate class of Multi-life. We have revised the form number to reflect this change.

We trust these forms will be acceptable for approval. Please feel free to contact me if you have any questions or need additional information. Thank you in advance for your attention.

Sincerely,

Sue R. Howard

Compliance Manager

Company and Contact

Filing Contact Information

Sue Howard, Compliance Manager Showard@lifesecureltc.com 10370 Citation Drive (810) 220-8774 [Phone] Brighton, MI 48116 (810) 220-7707[FAX]

Filing Company Information

LifeSecure Insurance Company CoCode: 77720 State of Domicile: Michigan 10559 Citation Drive Group Code: 572 Company Type: Life, A & H

Suite 300

Brighton, MI 48116 Group Name: BCBS of MI GRP State ID Number:

(810) 220-8774 ext. [Phone] FEIN Number: 75-0956156

Filing Fees

Fee Required? Yes
Fee Amount: \$170.00
Retaliatory? No

Fee Explanation: 6 forms at \$20.00 = \$120.00

1 Set of Rates= \$50.00

SERFF Tracking Number: LFSC-126136721 State: Arkansas

Filing Company: LifeSecure Insurance Company State Tracking Number: 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

Per Company: No

 SERFF Tracking Number:
 LFSC-126136721
 State:
 Arkansas

 Filing Company:
 LifeSecure Insurance Company
 State Tracking Number:
 42479

Company Tracking Number:

TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

COMPANY AMOUNT DATE PROCESSED TRANSACTION #
LifeSecure Insurance Company \$170.00 05/26/2009 28087248

 SERFF Tracking Number:
 LFSC-126136721
 State:
 Arkansas

 Filing Company:
 LifeSecure Insurance Company
 State Tracking Number:
 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|---------------------|----------------|------------|----------------|
| Approved- Closed | Harris Shearer | 06/12/2009 | 06/12/2009 |

SERFF Tracking Number: LFSC-126136721 State: Arkansas LifeSecure Insurance Company State Tracking Number: 42479

Filing Company:

Company Tracking Number:

TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number:

Disposition

Disposition Date: 06/12/2009

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

 SERFF Tracking Number:
 LFSC-126136721
 State:
 Arkansas

 Filing Company:
 LifeSecure Insurance Company
 State Tracking Number:
 42479

Company Tracking Number:

TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

| Item Type | Item Name | Item Status | Public Access |
|---------------------|---|-------------|---------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Health - Actuarial Justification | | Yes |
| Supporting Document | Outline of Coverage | | Yes |
| Supporting Document | Explanation of Variability | | Yes |
| Form | MultiLife Application-Agent Sold Paper | | Yes |
| Form | MultiLife Application-Online-Agent Sold | | Yes |
| Form | MultiLife Application-Self Serve | | Yes |
| Form | Schedule of Benefits | | Yes |

 SERFF Tracking Number:
 LFSC-126136721
 State:
 Arkansas

 Filing Company:
 LifeSecure Insurance Company
 State Tracking Number:
 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number: /

Form Schedule

Lead Form Number: LS-0204A ST 08/09

| Review Status | Form Number | Form Type Form Name | Action | Action Specific Data | Readability | Attachment |
|------------------|----------------------|--|---------|--|-------------|---|
| | LS-0204A ST 08/09 | Application/MultiLife Application- Enrollment Agent Sold Paper Form | Initial | | | LS-0204A ST 08.09 - Agent Sold Paper- John Doe.pdf |
| | LS-0204 ST 08/09 | Application/MultiLife Application- Enrollment Online-Agent Sold Form | Initial | | | LS-0204 ST 08.09-Online Screen Shots- Agent Sold- John Doe.pdf LS-0204 ST 08.09 - Online Agent Sold PDF John Doe.pdf |
| | LS-0205 ST 08/09 | Application/MultiLife Application- Enrollment Self Serve Form | Initial | | | LS-0205 ST 08.09- Online Self Serve Screen Shots John Doe.pdf LS-0205 ST 08.09- Online Self Serve PDF Output- John Doe.pdf |
| | LS-0051 ST 08/09 | Application/Schedule of Benefits Enrollment Form | Revised | Replaced Form #: LS-0051 ST 08/09 Previous Filing #: LS 0051 ST 05/07 | }- | LS-0051 ST 08.09_Sched ule of Benefits.pdf |

LifeSecure Insurance Company

Multi-Life Application

| SECTION | N . | PAGE |
|---------------|--|-------|
| Α | PERSONAL HEALTH HISTORY | 1 |
| В | APPLICANT INFORMATION | 2 |
| c | SPOUSE OR DOMESTIC PARTNER INFORMATION | 3 |
| D | COVERAGE SELECTIONS | 4-5 |
| E | PREMIUM PAYMENT AUTHORIZATION | 6 |
| Sections F, C | G and H are <i>not</i> required for those applicants who qualify for Simplified Issue. | |
| F | PERSONAL PHYSICIAN INFORMATION | 7 |
| G | MEDICAL HISTORY | 8-10 |
| н | APPLICANT PROFILE | 11 |
| | | |
| I | PROTECTION AGAINST UNINTENDED LAPSE OR TERMINATION | 12 |
| J | REPLACEMENT INQUIRY | 13 |
| K | OTHER NOTICES TO APPLICANT | 14-15 |
| L | APPLICANT AUTHORIZATIONS AND SIGNATURES | 16-17 |
| М | APPLICANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION | 18 |
| N | AGENT'S REPORT, CERTIFICATION AND SIGNATURE | 19-21 |

Section A: Personal Health History

| 1. | Within the past 12 months, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the past 12 months, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? | Yes | ☑ No |
|----|--|-------|-------------|
| 2. | Do you currently use any of the following: - Walker - Hospital bed - Wheelchair - Oxygen equipment - Quad Cane - Dialysis - Motorized scooter | Yes | ☑ No |
| 3. | Do you <i>currently</i> require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? | ☐ Yes | ☑ No |
| 4. | Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease) | Yes | ☑ No |
| | Systemic Lupus Disease Alzheimer's Disease Dementia/Senility Mental Retardation Psychosis Stroke (CVA) within past 5 years Multiple Sclerosis (MS) Muscular Dystrophy Parkinson's Disease Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test Metastatic Cancer Type I (Juvenile) Diabetes Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day A Transient Ischemic Attack (TIA) within past 2 years, or multiple TIAs within past 5 years Chronic Kidney/Renal Disease Huntington's Chorea Cirrhosis of the Liver Organ Transplant Amputation due to Disease (not accident) | | |
| 5. | Are you currently receiving Social Security Disability benefits? | Yes | ☑ No |
| | If you answered "Yes" to any part of any question in Section A, PLEASE DO NOT CO. We regret that we cannot offer you long term care insurance coverage. If your circumstances change, you may consider reapplying at a future time If you answered "No" to all questions in Section A, please CONTINUE. | | |

Section B: Applicant Information

| Employ | er/Group Name: <u>AB</u> | C Company | | Group Nu | mber: <u>00001</u> | , |
|---------------------------|---|---------------|--------------------------|--------------------|----------------------|-------------------------|
| Check (| ONLY one box below: | | | | | |
| I, the ap | oplicant, am: | | | | | |
| \square | an employee who re I am actively-at-work, workday before I cor | which means I | was working at | my usual place of | employment on the la | ast regularly scheduled |
| | a spouse or domestic His/her date of hire | | | | | |
| | a family member of a works less than [15] | • | • | | | ouse (who regularly |
| ❖ Mr. | ☐ Mrs. | ☐ Ms. | ☐ Dr. | | | |
| <u>John</u> | | | | <u>Doe</u> | | |
| Name (| First) | | (MI) | (Last) | | (Suffix) |
| | Nain Street | | | | | |
| Street A | Address | | | Apt # | | |
| Anytow | n | <u>ST</u> | | <u>1234</u> | | |
| City | | State | | Zip C | ode | |
| 01/01/ Date of | /1954 Birth (mm/dd/yyyy) | <u> </u> | | | | |
| 123 | <u>- 56 - 7756</u> | | | - | | |
| Social S | Security Number | • | OR Tax | Identification # | | |
| Gender | : | | Martial Statu | us: | | |
| ✓ Mal | e Female | | ☐ Single | ✓ Married | ☐ Domestic Partr | ner |
| | 9-2356 hone Number | | 810-235-65 Home Phone | | | |
| Best Tim | ne to Call: <u>9</u> a.m. <u>.</u> | <u>5</u> p.m. | | | | |
| Best Pla | ce to Call: 🗹 Work | ☐ Home | | | | |
| <u>iohnd@</u> E-mail 4 | yahoo.com | | Employee N | umber (if applicab | | |

Section C: Spouse Or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount. ☐ Mr. ✓ Mrs. ☐ Ms. Dr. Jane Doe Name (First) (Suffix) (MI) (Last) <u> 125 - 95 - 1236</u> Tax Identification # OR Social Security Number Is your spouse or domestic partner also applying for coverage? ☐ Yes ✓ No

Section D: Coverage Selections

| | DAINE. Emer a ac | | beiween ψ/ 5, | σσσ ana ψ | 1,000,00 | 00 <u>\$75,000</u> | | | · |
|-------------------------|---|---------------------|---------------------------------------|--------------|--------------------|------------------------------|---------------|------------------------------------|--------|
| | • | • | a Benefit Bank of this application | - | ıreater th | an [\$400,00 | 00], you will | be required to cor | nplete |
| HINC | HLY BENEFIT ACCESS | S LIMIT: | | | | | | | |
| | 1% of Benefit Bank 3% choice not availd | able for Ben | ☐ 2% of B efit Bank amou | | | _ | Benefit Bank* | | |
| our in | itial Monthly Benefit | Access Lim | it dollar amour | | 5,000 efit Bank | x | <u> </u> | 750 Monthly Benefit | |
| ONE | Y-BACK PROMISE O | PTION: | | 20110 | an Dank | | | Treatment Delice. | |
| $\overline{\checkmark}$ | Yes. I elect the Mo | ney-Back Pr | romise Option | as part of n | ny coverc | ige. | | | |
| | This optional bene choice if you shou | | | | | | benefits paid | d) to a beneficiary o | f your |
| | Please enter the Please note: If no l | | • | - | | • | | re such a refund, it ur estate. | any. |
| | Primary Beneficiar | y ☑ Cl | heck here if this | s is your Sp | ouse or [| Domestic Part | iner | | |
| | ☐ Mr. | Mrs. | ☐ Ms. | ☐ Dr | • | | | | |
| | Jane | | | | Doe | | | | |
| | Name (First) | | | (MI) | (Last) | | | (Suffix) | |
| | Wife | | | | | | | | |
| | Relationship | | | | | | | | |
| | 1234 Main Street | | | | _ | | | _ | |
| | | | | | | Apt# | | | |
| | Street Address | | | | | • | | | |
| | Anytown | | <u>ST</u> | | _ | <u>12</u> | 345 | | |
| | | | <u>ST</u> Sta | te | | <u>12</u> | 345 Code | | |
| | Anytown | iary ☑ Cl | Sta | | ouse or [| <u>12</u> Zi _k | o Code | | |
| | <u>Anytown</u> City | iary ☑ Cl] Mrs. | Sta | | | <u>12</u> Zi _k | o Code | | |
| | Anytown City Contingent Benefic | • – | Sta heck here if this | s is your Sp | | <u>12</u> Zi _k | o Code | (Suffix) | |
| | Anytown City Contingent Benefic Mr. | • – | Sta heck here if this | s is your Sp | ·. | <u>12</u> Zi _k | o Code | (Suffix) | |
| | Anytown City Contingent Benefic Mr. Name (First) | • – | Sta heck here if this | s is your Sp | ·. | <u>12</u> Zi _k | o Code | (Suffix) | |

LS-0204A ST 08/09

No. I reject the Money-Back Promise Option as part of my coverage.

| the ben | IAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare efits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options and 3% Automatic Compound Inflation Protection. My choice is as follows: |
|--------------|--|
| | I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature. |
| | I elect Automatic 5% Compound Inflation Protection. |
| | I elect Automatic 3% Compound Inflation Protection. |
| OPTION | IAL LAPSE PROTECTION BENEFIT: |
| \checkmark | Yes. I elect to have the Lapse Protection Benefit as part of my coverage. |
| | No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit. |
| PREMIU | M PAYMENT OPTIONS: |
| \checkmark | Lifetime Payment Option |
| | 10-Year Premium Payment Option* |
| | To-Age-65 Premium Payment Option* |
| | * These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage. |

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method. **AUTOMATIC PAYROLL DEDUCTION** (applicable only for participating employers) By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll. Payroll System/Division: Payroll Location: Payroll Frequency: Employee Number: **DIRECT-BILLING (MAIL)** $\sqrt{}$ Select one billing frequency: ✓ semi-annually annually quarterly monthly (\$2.00 monthly fee applicable) OR MONTHLY ELECTRONIC FUNDS TRANSFER П How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium. Monthly Electronic Funds Transfer Agreement: I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason. Name of Bank: Bank Address: _____ Telephone #: Account Type: \square checking \square savings Account #: Routing #: OR **AUTOMATIC CREDIT CARD PAYMENT** П Select Card Type: [Visa] [MasterCard] [American Express] [Discover Card] Credit Card #: _____ Name as it appears on Card: Expiration Date:

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

| (i.e., the physician with most of | formation about your pers your medical records). | sonal p | hysician, soi | metimes called your Pri | imary Care Dod |
|-------------------------------------|---|---------|---------------|-------------------------|----------------|
| James | | | Smith | | |
| Physician's Name (First) | () | MI) | (Last) | | (Suffix) |
| 5689 First Street | | | 500 | | |
| Street Address | | | Suite # | | |
| Anytown | | _ | _ | 12345 | <u></u> |
| City | State | | 7 | Zip Code | |
| 810-256-8956 Office Phone Number | | | | | |
| Office Frione Proffice | | | | | |
| Have you seen this physician ir | the last two years? | | ✓ Yes | ☐ No | |
| Date of last visit: 01/2009 | | | | | |
| month/y | rear | | | | |
| D (| | | | | |
| Reason for visit: | | | | | |
| Annual Physical | | | | | |

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

Section G: Medical History

| 1. | | | st 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a professional for any of the following conditions (check all that apply or NONE OF THE ABOVE). |
|----|--------------|--------------|--|
| | \checkmark | 1. | Drug or Alcohol Abuse |
| | | 2. | Disorders of Vision or Speech |
| | | 3. | Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease |
| | | 4. | Heart Attack, Angioplasty or Heart Surgery |
| | | 5. | Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery |
| | | 6. | Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker |
| | | 7. | Aneurysm, Peripheral Vascular Disease (PVD) |
| | | 8. | Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis |
| | | 9. | Fainting Spells or Blacking Out, Seizures, Epilepsy |
| | | 10. | Tremor, Myasthenia Gravis |
| | | 11. | Paralysis (partial or full), Post Polio Syndrome |
| | | 12. | Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma |
| | | 13. | Depression, Schizophrenia, or other forms of Mental Illness |
| | | 14. | Diabetes, Disease of the Pancreas or other glands |
| | | 15. | Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease |
| | | 16. | Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement |
| | | 1 <i>7</i> . | Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone |
| | | 18. | Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease |
| | | NOI | NE OF THE ABOVE |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Number | Dates From/To | Physician's Name/Address/Phone | Describe | |
|------------|---|---|----------------------------|------|
| 01 | 01/1985 to 01/2006 | James Smith, Anytown, ST 12345 810-256-8956 | Prescription Drug Abuse | |
| | | | | |
| an If " | y other health condition Yes", please describe | e you had any symptoms or knowledge of on that is not disclosed above? | ✓ Yes | □ No |
| | cid Reflux | | | |
| | the <i>past 3 years,</i> have | | √ Yes | П № |
| . In t | taken any presci | ription medications (if "Yes", please list)? | ✓ Yes Reason | □ No |
| a. | . , | | ✓ Yes Reason Acid Reflux | □ No |
| a. | taken any presci | ription medications (if "Yes", please list)? Dosage | Reason | □ No |
| a. | taken any presci | ription medications (if "Yes", please list)? Dosage | Reason | □ No |

| C. | | been treated for any rease ER THAN your Primary Co | | √ Yes | □ No |
|----------|---|--|---------------------------------------|--------------|---------|
| | | rovide the Healthcare Pro consulted and dates. | essional's name, locat | ion, | |
| | Name | City & State | Specialty | Reason(s) | Dates |
| | Dave Jones | Anytown, ST | Gastro Interology | Acid Reflux | 01/2000 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | <u>I</u> | |
| d. | - | a healthcare professional or a surgery that has not | • | ✓ Yes | □ No |
| d. | evaluation testing | or a surgery that has not xplain type, reason and so | been performed? | √ Yes | □ No |
| d. | evaluation testing If "Yes", please e evaluation, testing | or a surgery that has not xplain type, reason and so | been performed? | ✓ Yes | □ No |
| d. e. | evaluation testing If "Yes", please e evaluation, testing Endoscopy, Not S | or a surgery that has not xplain type, reason and so | been performed? cheduled date of the | ✓ Yes ✓ Yes | □ No |

DO <u>NOT</u> COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

| С | tion H: Applican | t Profi | le | | | |
|---|--|-----------------------|-------------------------|------------------|-------------------|-------------|
| | Please provide your height <u>6 ft 2</u> | <u>2 in</u> (ft. & ir | n.) and weight <u>2</u> | <u>50</u> (lbs.) | | |
| | In the past 3 years, have you use | ed any form | of tobacco or nico | tine product? | ✓ Yes | □ No |
| | Date last used | | List types of | of tobacco or ni | cotine products u | ısed |
| | 05/18/2009 | | Cigarette | | | |
| | | | | | | |
| | Do you work 20 or more hours a If "Yes", please list your occupati | | • | | √Yes | □ No |
| | Do you drive an automobile? If "Yes", please provide approxir | mate annual | mileage: | miles | ☐ Yes | ☑ No |
| | With whom do you live? | alone | ✓ spouse | ☐ family | other | |
| | Do you live in some form of a res If "Yes", please list the specific se (e.g., housekeeping, laundry, me | ervices that y | • | · | √ Yes | □ No |
| | Driving, Laundry | | | | | |
| | | | | | | |
| | In the past 3 years, have you had insurance application denied? If "Yes", by which company? | d any nursin | g home or long ter | m care | ✓ Yes | □ No |
| | MetLife | | | | | |

Section I: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

| Please check one of the follow | ving: | | | |
|--------------------------------|----------------------|--------------|-----------------------|----------|
| ☐ I elect NOT to design | ate another person | to receive t | his notice. | |
| ✓ I elect to designate a | nother person to rec | eive this no | tice. | |
| Complete the information belo | ow ONLY if you elec | t to name c | ın authorized person. | |
| Jane | | | Doe | |
| Name (First) | | (MI) | (Last) | (Suffix) |
| 1234 Main Street | | | | |
| Street Address | | | Apt # | |
| Anytown | <u>ST</u> | | 12345 | |
| City | State | | Zip Code | |
| 810-235-6598 | | | | |
| Phone Number | | | | |
| | | | | |

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section J: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage.

All questions must be answered.

| 1. | Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? | ✓ Yes | ☐ No |
|----|---|--------------|------|
| | If "Yes", provide details: | | |
| | Company Name: John Handcock | | |
| | Individual or Group Policy Number: 012562356 | | |
| | Type of Coverage: Long Term Care | | |
| 2. | Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? | √ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | If that policy lapsed, when did it lapse? 01/2008 | | |
| 3. | Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? | ✓ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | Company Address: 1245 Granger, Anytown, ST 12345 | | |
| | -OR- | | |
| | Individual or Group Policy Number: 0152365 | | |
| 4. | Are you currently covered by Medicaid? (not a reference to Medicare) | ✓ Yes | □ No |

LEAVE THIS PAGE WITH THE APPLICANT. DO NOT SUBMIT WITH APPLICATION.

Section K: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau P.O. Box 105, Essex Station Boston, Massachusetts 02111 866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company 10559 Citation Drive, Suite 300 Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony.

Section L: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☑ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

| | K THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION J HER COVERAGE OR POLICY WITH THIS NEW COVERAGE. | of this application that you plan to replace |
|-----------|--|--|
| | I acknowledge that I have read the Notice to Applicant Rego or Long Term Care Insurance. That particular notice was deliv | · · |
| I certify | y that I have read, or have had read to me, the competed Appli | cation. |
| | n: I understand that if any of my answers on this Application openefits or rescind my policy. | re incorrect or untrue, LifeSecure may have the right to |
| I under | rstand that I, or my authorized representative, may request to r | eceive a copy of this authorization. |
| My sigi | nature below represents my acknowledgement, acceptance and | authorization of all statements checked above. |
| John D | loe | 01/01/1954 |
| Applica | ant's Name | Date of Birth |
| | | <u>7756</u> |
| Applica | ant's Signature | Last 4 Digits of SSN |
| I certify | y that I have signed the application in: <u>Anytown, ST</u> | on Date: <u>05/18/2009</u> |
| | City, State | |

Section M: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

| John Doe | <u>01/01/1954</u> |
|-------------------------------|----------------------------|
| Applicant's Name | Date of Birth |
| | <u>7756</u> |
| Applicant's Signature | Last 4 Digits of SSN |
| Signed at: <u>Anytown, St</u> | on Date: <u>05/18/2009</u> |
| City, State | |

Section N: Agent's Report, Certification and Signature

| Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? | ✓ Yes | ☐ No |
|---|-----------------|--------------|
| If "No", please provide details in the "Remarks" section below. | | |
| Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? | √ Yes | □ No |
| If "Yes", please provide details in the "Remarks" section below. | | |
| Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? | √ Yes | □ No |
| If "Yes", please provide details in the "Remarks" section below. | | |
| Please list other health insurance policies sold by you to the applicant: | | |
| N/A | | |
| N/A | | |
| | ve years that c | are no longe |
| Please list other health insurance policies sold by you to the applicant in the last fi force. John Hancock Long Term Care | ve years that c | are no longe |
| Please list other health insurance policies sold by you to the applicant in the last fi force. John Hancock Long Term Care | ve years that c | are no longe |
| Please list other health insurance policies sold by you to the applicant in the last fi force. John Hancock Long Term Care Please list all policies that the applicant has in force: | ve years that c | are no longe |
| Please list other health insurance policies sold by you to the applicant in the last fi force. John Hancock Long Term Care Please list all policies that the applicant has in force: | ve years that c | are no longe |
| Please list other health insurance policies sold by you to the applicant in the last fi force. John Hancock Long Term Care Please list all policies that the applicant has in force: MetLife Is this policy intended to replace any of the above listed policies or any other | ve years that c | are no longe |

| 8 | If this application is approved, the Policy Welcome Kit should be sent to the: Policyholder | | | | | | | | |
|-------------------------|--|--------------------|---------------|-------------------------|---------------------------|--|--|--|--|
| | ☐ Sales Agent (Select Agent Name in | Case Split Inform | ation section | on on next page, if app | licable.) | | | | |
| | If sent to the Policyholder, please select | an address: | | | | | | | |
| | ✓ Policyholder Home Address (listed i | in Section B) | | | | | | | |
| | ■ New Shipping Address: | | | | | | | | |
| | Name (First) | (MI) | (| Last) | (Suffix) | | | | |
| | Street Address | | Apt # | | | | | | |
| | City | State | | Zip Code | | | | | |
| | Phone Number | | | | | | | | |
| $\overline{\checkmark}$ | I have truthfully and accurately recorde application. | ed the information | n supplied | to me by the applica | nt for completion of this | | | | |
| | I have provided the applicant copies, et Term Care Insurance, Outline of Coverage Term Care Insurance. | | | | | | | | |
| $\overline{\checkmark}$ | I have provided the applicant a copy of the information on their Personal Worksh | | rksheet an | d have explained the ir | nportance of completing | | | | |
| | (THE BOX BELOW ONLY IF THE APPLI TO REPLACE ANOTHER COVERAGE OR | | | | Cation that he/she | | | | |
| V | I acknowledge that I have provided the a Accident and Sickness or Long Term Car | • • | Notice to | Applicant Regarding R | eplacement of Individua | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| Case S | plit Information (if applicable) | |
|--------------|--|-----------------------------|
| Check | one box for Agent to receive Welcome Kit | |
| \checkmark | Agent Name <u>Martin Long</u> | % Split <u>100</u> |
| | Agent License # 1256892222 | Contract #: <u>00000123</u> |
| | LifeSecure ID # <u>00000001</u> | |
| | Agent Name | % Split |
| | Agent License # | Contract #: |
| | LifeSecure ID # | |
| | Agent Name | % Split |
| | Agent License # | Contract #: |
| | LifeSecure ID # | |
| | | 100% |
| | | 100% |

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

| Soliciting Agent's Signature | | <u>05/18/2009</u> Date | |
|--|------|-------------------------------|--|
| Martin Soliciting Agent's Name (First) | (MI) | Long (Last) | |
| 00000001 LifeSecure ID # | | 1256892222 Agent License # | |
| 00000123 Contract # | | | |



| Log Out | | | | | |
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| Application Tools You | r Workspace | | | | |
| Application | LTC Application: Section A B C D E F G H I J K L M N | | Ne | xt | |
| Saved Application | Section A: Personal Health History | | | | |
| Quote Calculator | Within the <i>past 12 months</i> , have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of | | Yes | © | No |
| Resource Center | Long Term Care Facility? Or, within the <i>past 12 months</i> , have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? | | | | |
| | Do you currently use any of the following: Walker Wheelchair Quad Cane Motorized scooter Hospital bed Oxygen equipment Dialysis | C | Yes | 0 | No |
| | 3. Do you <i>currently</i> require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? | | Yes | 0 | No |
| | 4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: | | Yes | © | No |
| | Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease) Systemic Lupus Disease Alzheimer's Disease Dementia/Senility Mental Retardation Psychosis Stroke (CVA) within past 5 years Multiple Sclerosis (MS) Muscular Dystrophy Parkinson's Disease Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test Metastatic Cancer Type I (Juvenile) Diabetes Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day A Transient Ischemic Attack (TIA) within past 2 years, or multiple TIAs with past 5 years Chronic Kidney/Renal Disease Huntington's Chorea Cirrhosis of the Liver Organ Transplant Amputation due to Disease (not accident) | iin | | | |
| | 5. Are you <i>currently</i> receiving Social Security Disability benefits? | | Yes | 0 | No |
| | | Bos | set | Nov | /+ |



| Application Tools You | r Workspace |
|-------------------------|---|
| Application | LTC Application: Section A B C D E F G H I J K L M N |
| Saved Application | Section B: Applicant Information |
| | Employer/Group Name: ABC COMPANY |
| Quote Calculator | Group Number: 00001 |
| Resource Center | Check ONLY one box below: I, the applicant, am: |
| | an employee who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application. |
| | My date of hire was: 01/01/2005 |
| | month/year |
| | a spouse or domestic partner of an eligible employee of the employer named above. |
| | His/her date of hire was: |
| | month/year |
| | a family member of an eligible employee, or a retiree/spouse, or a part-time employee/spouse (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above. |
| | E Mr. C Mrs. C Ms. C Dr. |
| | JOHN DOE |
| | Name (First) (MI) (Last) (Suffix) |
| | 1234 Main Stree |
| | Street Address |
| | |
| | Apt. # |
| | Anywhere ST 12345 |
| | City State Zip Code |
| | 01 , 01 , 1954 123 56 7756 |
| | Date of Birth (mm/dd/yyyy) Social Security # OR Tax Identification # |
| | Gender: Marital Status: |
| | ☑ Male ☐ Female ☐ Single ☑ Married ☐ Domestic Partner |
| | |
| | 810 659 2356 810 235 6598 |
| | Work Phone Number Home Phone Number |
| | Best Time to Call: 9 a.m. 5 p.m. |
| | Best Place to Call: Work Home |
| | JOHND@YAHOO.COM |
| | JOHNS TATIOO.COM |



Log Out | | Application Tools | Your Workspace | LTC Application: Section A B \subseteq D E F G H I J K L M N Next Application **Section C: Spouse or Domestic Partner Information** Saved Application PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount. Quote Calculator C Mr. Mrs. Dr. Ms. Resource Center JANE DOE Name (First) (MI) (Last) (Suffix) 125 5236 Social Security # OR Tax Identification # Is your spouse or domestic partner also applying for coverage? Yes No Reset Previous Next Save



| Application Tools Yo | ur Workspace | | | | | | |
|------------------------|---|---|--|---|-------------------|---------------------|--|
| Application | LTC Application: Se | ection A B | CDEFG | HIJKL | M N | | Next |
| Saved Application | Section D: Coverage | ge Selectior | าร | | | | |
| Затеа Аррисанон | BENEFIT BANK: | | | | | | |
| Quote Calculator | Enter a dollar amount be | etween \$75,000 | and \$1,000,00 | \$75,000 | | | 00 101 001 001 001 001 001 001 001 001 |
| Resource Center | MONTHLY BENEFIT AC | CESS LIMIT: | | | | | |
| | 1% of Benefit Bar | nk 🖸 2 | % of Benefit Ba | ank 🖸 39 | % of Benefit Bank | (* | |
| | * 3% choice not ava | ailable for Benef | fit Bank amoun | its greater than \$5 | 500,000. | | |
| | Your initial Monthly Bene | fit Access Limit | dollar amount | 75,000 Benefit Bank | X _1_% = | \$750 Monthly Be | nefit |
| | MONEY-BACK PROMIS | E OPTION: | | | | | |
| | Yes, I elect to have | | ack Promise Op | otion as part of my | coverage. | | |
| | This optional ben beneficiary of you | | | f a percentage of e holding your pol | | | paid) to a |
| | Please enter the name of Please Note: If no benefit | | | | | | ınd, if any |
| | Primary Beneficiary | Check | k here if this is | your Spouse or D | omestic Partner | | |
| | ☐ Mr. ☐ Mrs. | C Ms. | 🖸 Dr. | | | | |
| | Nome (First) | (MI) | (Loot) | | | (Cuffix) | |
| | Name (First) | (MI) | (Last) | | | (Suffix) | |
| | Relationship | | | | | | |
| | Street Address | | | | | | |
| | City | | State | y Zip Code | | | |
| | | | N 1 1 15 15 15 15 15 15 15 15 15 15 15 15 | | D D | | |
| | Contingent Beneficiary Mr. Mrs. | ⊈ □ C □ Ms. | Theck here if the | is is your Spouse | or Domestic Parti | ner | |
| | L IVII 3. | L IVIS. | | | | | - |
| | Name (First) | (MI) | (Last) | | | (Suffix) | |
| | Relationship | | | | | | |
| | | | 200 min 100 mi | | | | |
| | Street Address | | 100 | 3.0 | | | |
| | City | | State | Zip Code | | | |
| | No. I reject the M | oney-Back Pron | nise Option as | part of my coverage | ge. | | |
| | OPTIONAL AUTOMATI graphs that compare the Specifically, I have revie as follows: | benefits and p | remiums of the | e policy with and v | without automati | c inflation | protection |
| | ☐ I reject the Autom will include the Gu | 146-91-1465-511-661-1266-12466-1-1-691-1466-1-1-460-1-1 | | | wever, I understa | and that m | y coverage |
| | | 5% Compound | Inflation Protei | ction. | | | |
| | • I cicci natomatic | e /e eempeana | | | | | |



| Log Out | |
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| Application Tools Your | Workspace |
| Application Saved Application | OPTIONAL LAPSE PROTECTION BENEFIT: Yes. I elect to have the Lapse Protection Benefit as part of my coverage. No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit. |
| Quote Calculator | Premium Payment Options: Lifetime |
| Resource Center | Total Monthly Premium[**]: \$\frac{750}{[** If the employer stops contributing to your long term care insurance coverage for any reason in the future the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.] |
| | Save Reset Previous Next |



| Application Tools You | ur Workspace | |
|-------------------------|---|---|
| | | |
| Application | LTC Application: Section A B C D E F G H I J K L M N | Next |
| Saved Application | Section E: Premium Payment Authorization | |
| Quote Calculator | Complete this section to authorize your preferred premium payment method. | _ |
| Resource Center | By electing this payment method, I authorize my employer to deduct my long term | care insurance |
| | premiums automatically from my payroll. Payroll System/Division: Payroll Location: Payroll Frequency: Employee Number: | |
| | | _ |
| | ☑ DIRECT BILLING (MAIL) | |
| | Select billing frequency: | |
| | annually semi-annually quarterly monthly (\$2.00 monthly | fee applicable) |
| | MONTHLY ELECTRONIC FUNDS TRANSFER | |
| | offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will term care insurance premiums from your bank account electronically. You do not need to mail in any payments. Premium withdrawals will appear on your bank statement, and y will be your receipts for payment of your premium. Monthly Electronic Funds Transfer Agreement: I authorize LifeSecure to electronically withdraw money from my account for the payme for this insurance policy. I authorize LifeSecure to continue to make these withdrawa renewal, or other change in the policy. I will compensate LifeSecure for any loss, claused by these withdrawals and will not hold LifeSecure responsible for any such loss, claused by these withdrawals and will not hold LifeSecure responsible for any such loss, claused by these withdrawals and will not hold LifeSecure responsible for any such loss, claused by the policy. Authorizing this automatic pay not put the insurance policy into effect. This authorization may be retracted by me or Lift time for any reason by giving written notice. LifeSecure may retract the authorization without giving me written Notice, if any debt is not paid by the bank stated below, for any Name of Bank: Bank Address: Telephone #: | write checks of your statement and of premiumals if there is a aim, or liability aim, or liability ment plan doe feSecure at any on immediately |
| | Routing #: | |
| | ☐ AUTOMATIC CREDIT CARD PAYMENT | |
| | Select Card Type: [Visa] [MasterCard] [American Express] [Discov | ver Card] |
| | Credit Card #: (do not enter dashes or spaces | s) |
| | Name as it appears on Card: | |
| | Expiration Date: / | |



Log Out Application Tools | Your Workspace | LTC Application: Section A B C D E F G H I J K L M N Next Application Section F: Personal Physician Information Saved Application Please provide the following information about your personal physician, sometimes called your Quote Calculator Primary Care Doctor (i.e., the physician with most of your medical records). **JAMES** SMITH Resource Center (Last) (Suffix) Physician's Name (First) (MI) 5689 1ST STREET **Street Address** 500 Suite # ANYTOWN ST 12345 Zip Code City State 256 8956 Office Phone Number Have you seen this physician in the last two years? Yes No 09 Date of last visit: year month ANNUAL PHYSICAL Reason for visit: Previous Save Reset Next



| Application wasted to | - W | | |
|-------------------------|-------------|--|--------|
| Application Tools You | r Workspace | | |
| Application | LTC App | olication: Section A B C D E F <u>G</u> H I J K L M N | Nex |
| Saved Application | Section | G: Medical History (Part 1) | |
| Quote Calculator | COI | the <i>past 3 years</i> , have you received medical advice or treatment, been diagnose insulted with a healthcare professional for any of the following conditions (check all that when the conditions). | |
| Resource Center | | | |
| | | 1. Drug or Alcohol Abuse | |
| | | 2. Disorders of Vision or Speech | |
| | | 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease | |
| | | 4. Heart Attack, Angioplasty or Heart Surgery | |
| | | 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery | |
| | | 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker | |
| | | 7. Aneurysm, Peripheral Vascular Disease (PVD) | |
| | | 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bron | chitis |
| | | 9. Fainting Spells or Blacking Out, Seizures, Epilepsy | |
| | | 10. Tremor, Myasthenia Gravis | |
| | | 11. Paralysis (partial or full), Post Polio Syndrome | |
| | | 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myel | oma |
| | | 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness | |
| | | 14. Diabetes, Disease of the Pancreas or other glands | |
| | | 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disea | ase |
| | | 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement | |
| | | 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone | |
| | | 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease | |
| | | NONE OF THE ABOVE | |



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Application Tools | Your Workspace |

Application

LTC Application: Section A B C D E F G H I J K L M N

Next

Saved Application

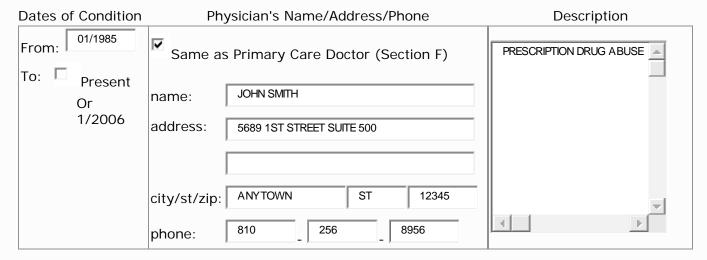
Quote Calculator

Resource Center

Please give details below to all boxes checked in Question #1 of this section.

1. Drug or Alcohol Abuse

Section G: Medical History (Part 2)



Save Reset Previous Next



Log Out | | Application Tools | Your Workspace | Next LTC Application: Section A B C D E F G H I J K L M N Application Section G: Medical History (Part 3) Saved Application 2. In the past 3 years, have you had any symptoms or knowledge of any other health E Yes C No **Quote Calculator** condition that is not disclosed above? Resource Center Please describe: ACID REFLUX 3. In the past 3 years, have you: E Yes L No a. taken any prescription medications? (if yes, please list) Reason Medication Dosage **NEXIUM** 50 MG ACID REFLUX **NEXIUM** 50 MG ACID REFLUX Add **E** Yes □ No b. been confined in or advised to enter a hospital or rehabilitation facility? Please explain and include dates and reasons: 01/1986 REHAB CLINIC FOR PRESCRIPTION DRUG ABUSE c. consulted with or been treated for any reason by a healthcare professional C Yes C No OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted Name/Location/Specialty **Reason Consulted Dates** DAVE JONES/ANYTOWN, ST/ **ACID REFLUX** 01/2000 GATSTRO INTEROLOGIST Add d. been advised by a healthcare professional to have a special evaluation, testing Yes No or a surgery that has not been performed? Please explain type, reason and scheduled date of the evaluation, testing or e. required assistance with shopping, using transportation, housekeeping, E Yes C No cooking or taking medications? Please explain and include dates and reasons: Previous Next Save Reset LS-0204 ST 08/09



Log Out Application Tools | Your Workspace | Next LTC Application: Section A B C D E F G \underline{H} I J K L M N Application Section H: Applicant Profile Saved Application 1. Please provide your height ft. in., and weight lbs. Quote Calculator Resource Center 2. In the past 3 years, have you used any form of tobacco or nicotine product? E Yes C No **Date Last Used Types of Tobacco or Nicotine Products Used** 5/18/2009 cigarettes 12/12/2005 cigarettes Add 3. Do you work 20 or more hours a week outside your home? C Yes C No Financial Analyist Please list your occupation: 4. Do you drive an automobile? C Yes C No Please provide approximate annual mileage: 5. With whom do you live? **E** alone □ spouse □ family □ other 6. Do you live in some form of a residential retirement community? E Yes C No Please list the specific services that you are receiving (e.g., housekeeping, laundry, meals): Driving, Laundry **E** Yes □ No 7. In the past 3 years, have you had any nursing home or long term care insurance application denied? By which company? MetLife Reset Previous Next



Log Out Application Tools | Your Workspace | Next LTC Application: Section A B C D E F G H | J K L M N Application Section [F] [I]: Protection Against Unintended Lapse or Termination Saved Application I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand Quote Calculator that notice will not be given to this person until 30 days after a premium is due and unpaid. Please check one of the following: Resource Center I elect NOT to designate another person to receive this Notice. I elect to designate another person to receive this Notice. Complete the information below ONLY if you elect to name an authorized person. JANE DOE Name (First) (MI) (Last) (Suffix) 1234 MAIN ST **Street Address** Apt. # ANYTOWN 12345 ST City State **Zip Code** 810 3598 **Phone Number** You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

LS-0204 ST 08/09

Save

Reset

Previous

Next



Log Out | | Application Tools | Your Workspace | Next LTC Application: Section A B C D E F G H I J K L M N Application Section [G] [J]: Replacement Inquiry Saved Application Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered. **Quote Calculator** 1. Do you have another long term care insurance policy or certificate in force Resource Center Yes No (including a health care service contract or health maintenance organization contract)? Please provide the following details: JOHN HANDCOCK Company Name: 012562356 Individual or Group Policy Number: LONG TERM CARE Type of Coverage: 2. Did you have another long term care, nursing home, or home health care Yes No insurance policy or certificate in force during the past 12 months? With which company? | METLIFE 01/2008 If that policy lapsed, when did it lapse? 3. Did you intend to replace the above or any other long term care, medical or Yes No health insurance with this coverage? If "Yes", provide details: **METLIFE** Company Name: 1245 GRANGER, ANYTOWN, ST Company Address: -OR-Individual or Group Policy Number: Are you currently covered by Medicaid? (not a reference to Medicare) Yes No

Previous

Next

Save

Reset



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L M N

Next

Section [H] [K]: Other Notices to Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a Non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau P.O. Box 105, Essex Station Boston, Massachusetts 02111 866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company 10559 Citation Drive, Suite 300 Brighton, MI 48116

in fo@Your Life Secure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

To residents of **Kentucky**: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.



Log Out | | Application Tools | Your Workspace | To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and Application may be subject to civil fines and criminal penalties. To the residents of **Oklahoma**: WARNING: Any person who knowingly and with intent to injure, defraud, or Saved Application deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony. Quote Calculator Save Reset Previous Next Resource Center LS-0204 ST 08/09



Resource Center

| Log Out | |
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| Application Tools You | ur Wörkspace |
| Application | LTC Application: Section A B C D E F G H I J K L M N |
| Saved Application | Section [I] [L]: Applicant Authorization and Signatures |
| Quote Calculator | Your signature, whether electronic or handwritten, represents your acknown authorization of each statement checked below. The first four statements in Application can be processed. The remaining statements must be accepted by processed apply if you elected the optional choices referenced in those statements. |

Next

wledgement, acceptance and nust be accepted before your efore your Application can be ts. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section [H] [K] of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ▼ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F] [I] of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. 2009 That particular notice was delivered to me on: | 05

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

Date: 05

/ 18

/ 2009

| I certify that I have signed the Application in City State The applicant must sign the Application by voice authorization code entry or by signature | |
|---|-----------|
| | Ð |
| The applicant must sign the Application by voice authorization code entry or by signature Application. Please indicate the method of signature below: Voice Authorization Code Voice Authorization Code | via faxed |
| Signature Via Faxed Application | |
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Resource Center

| Log Out | | |
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| Application Tools You | r Workspace | |
| Application | LTC Application: Section A B C D E F G H I J K L M N | Next |
| Saved Application | Section [J] [M]: Applicant Authorization to Obtain and Disclose Int | ormation |
| Quote Calculator | This authorization is designed to satisfy the requirements of the Health Insuran- | ce Portability and |

By signing this authorization form, I agree to the following:

Accountability Act of 1996, as it may be amended from time to time (HIPAA).

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

| Clicking "Accept" represents my acknowledgement and understar C ACCEPT C DECLINE | nding o | f all stat | tements ab | ove. |
|---|---------|------------|------------|------|
| Applicant's Voice Authorization Code: 0125623 Date: 05 | / 18 | / | 2009 | |
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| LS-0204 ST 08/09 | | | | |



Log Out | | Application Tools Your Workspace Next LTC Application: Section A B C D E F G H I J K L M N Application Section [K] [N]: Agent's Report Saved Application How long have you known the applicant? 6 Y Quote Calculator **Statements** Yes No 1. Did you personally see the applicant on the date of this Application, ask each question, and accurately record the answers yourself? Resource Center If "No", please provide details in the "Remarks" section below. 2. Are you aware of any information that would adversely affect the applicant's Yes No eligibility, acceptability, or insurability? If "Yes", please provide details in the "Remarks" section below. 3. Did you observe any physical or mental impairments with regard to walking, Yes No talking, or any form of tremor? If "Yes", please provide details in the "Remarks" section below. 4. Please list other health insurance policies sold by you to the applicant: N/Α ^{5.} Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force. JOHN HANDCOCK LONG TERM CARE 6. Please list all policies that the applicant has in force: **METLIFE** 7. Is this policy intended to replace any of the above listed policies or any other long Yes No term care, medical or health insurance? Remarks HIS IS A SMOKER AND HAS A BAD HAND TREMOR $^{\hbox{8.}}\,\,$ If this Application is approved, the Policy Welcome Kit should be sent to the: Policyholder Sales Agent (Select Agent Name in Case Split Information section below.) If sent to the policyholder, please select an address: Policyholder Home Address **New Shipping Address** Name (First) (Last) (Suffix) **Street Address** Apt. # Zip Code City State **Phone Number** LS-0204 ST 08/09



| Log Out | | | | | | | | | |
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| Application | | | hfully and ac of this Applicat | ccurately recorded th | e inform | ation supp | lied to | me by the a | applicant |
| Saved Application | | I have provi | ided the appli | cant copies, either pri nsurance, Outline of C | | | | | |
| Quote Calculator | | A Shopper's I have provi | Guide to Long ded the applic | g Term Care Insurance cant a copy of the Pers | sonal Woi | | | | |
| Resource Center | | completing t | the information | n on their Personal Wo | rksheet. | | | | |
| | | | | Y IF THE APPLICANT S ACE ANOTHER COVERA | | | | | |
| | V | | | e provided the applicar Sickness or Long Tern | | | Applic | ant Regarding | Replacem |
| | 10-000-000-000-000-000-000-000-000-000- | TIN LONG ting Agent's Nan | me | 00000001 LifeSecure I | D# | 125689222 Agent Lice | | | |
| | 05 Date | / 18 | / 2009 | 1256892222 Contract Number | | | | | |
| | Case | Split Inform | ation (if app | licable) | | | | | |
| | | | | ve Welcome Kit | | Agent Lice | ense | Contract# | O/ Enli |
| | © [| LifeSecure ID | MARTIN LONG | Agent Name | | 1256892222 | _ _y[| 125 | % Spli |
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Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L M N

Next

Live Chat Session

Once you have submitted this on-line Application, you may initiate a Live Chat session to engage an underwriter to evaluate the Application responses and approve the Application, if possible.

However, if a face-to-face interview, phone history interview or request for medical records is required, please inform the applicant that it may take additional business days to fully evaluate the Application and provide a final decision. (Note: Such additional requirements are not applicable to applicants who qualify for Simplified Issue Underwriting.)

Coverage Summary

Premium Plan: [Lifetime Payment Option]

[10-Year Payment Option] [To-Age-65 Option]

| Benefit Bank Amount | [\$75,000 - \$1,000,0000] |
|------------------------------|------------------------------------|
| Monthly Benefit Access Limit | [\$XX,XXX] [(1%)] [(2%)] [(3%)] |
| Monthly Premium | [\$XXX.XX] |
| Benefit Wait Period | [90] calendar days |
| Other Benefits Included | |
| | |

Previous Submit Competed Application

Section A: Personal Health History

| 1. | Within the past 12 months, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the past 12 months, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? | Yes | √ No |
|----|---|-------|-------------|
| 2. | Do you currently use any of the following: - Walker - Wheelchair - Quad Cane - Motorized scooter - Hospital bed - Oxygen equipment - Dialysis | ☐ Yes | √ No |
| 3. | Do you <i>currently</i> require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? | Yes | ☑ No |
| 4. | Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: | ☐ Yes | ☑ No |
| E | Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease) Systemic Lupus Disease Alzheimer's Disease Dementia/Senility Mental Retardation Psychosis Stroke (CVA) within past 5 years Multiple Sclerosis (MS) Muscular Dystrophy Parkinson's Disease Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test Metastatic Cancer Type I (Juvenile) Diabetes Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day A Transient Ischemic Attack (TIA) within past 2 years, or multiple TIAs within past 5 years Chronic Kidney/Renal Disease Huntington's Chorea Cirrhosis of the Liver Organ Transplant Amputation due to Disease (not accident) | Yes | □ No |
| 5. | Are you currently receiving Social Security Disability benefits? | | ✓ No |
| | If you answered "Yes" to any part of any question in Section A, PLEASE DO NOT CO We regret that we cannot offer you long term care insurance coverage. If your circumstances change, you may consider reapplying at a future time | | |

Section B: Applicant Information

| Employ | er/Group Name: <u>AE</u> | BC Company | | Group Nu | mber: <u>00001</u> | |
|----------------|---|--------------------|--------------------|----------------------|---|-----------------------|
| Check (| ONLY one box below: | | | | | |
| I, the ap | oplicant, am: | | | | | |
| Ø | I am actively-at-work | , which means I w | as working at m | y usual place of | er week for the employ employment on the las 1/01/2005 (m | st regularly schedule |
| | a spouse or domestic His/her date of hire | - | | • • • | | |
| | a family member of a works less than [15] | | | • | rt-time employee/spou amed above. | se (who regularly |
| ☑ Mr. | ☐ Mrs. | ☐ Ms. | ☐ Dr. | | | |
| John | | | | Doe | | |
| Name (| First) | | (MI) | (Last) | | (Suffix) |
| | Nain Street | | | | | |
| Street A | Address | | | Apt # | | |
| Anytow City | 'n | <u>ST</u> State | | <u>1234</u> Zip C | | |
| 01/01/ | /1054 | Sidie | | Zip C | ode | |
| | Birth (mm/dd/yyyy) | | | | | |
| | <u>- 56 - 7756</u> | | | - | | |
| | Security Number | 0 | R Tax lo | dentification # | | |
| ~ I | | | A4 .: 1 C | | | |
| Gender | | | Martial Status | | | |
| ☑ Male | e | | ☐ Single | | ■ Domestic Partne | er |
| | 9-2356 | | <u>810-235-659</u> | | | |
| | hone Number | _ | Home Phone | Number | | |
| | ne to Call: <u>9</u> a.m. <u>.</u> | <u>5</u> p.m. | | | | |
| Best Pla | ice to Call: 🗹 Work | ☐ Home | | | | |
| | yahoo.com | | | | | |
| E-mail A | Address | | Employee Nu | mber (if applicab | ole) | |

Section C: Spouse Or Domestic Partner Information

| PLEASE COMPLETE THE INFORM. You may qualify for a couple's di | | er or not your spouse or domestic | C PARTNER IS APPLYING. |
|--|---------------------------|-----------------------------------|------------------------|
| ☐ Mr. ☑ Mrs. | ☐ Ms. ☐ Dr. | | |
| Jane | | <u>Doe</u> | |
| Name (First) | (MI) | (Last) | (Suffix) |
| <u>125 - 95 - 1236</u> Social Security Number | OR | Tax Identification # | _ |
| Is your spouse or domestic partne | er also applying for cove | erage? | |

Section D: Coverage Selections

| NIHLY BEN | EFIT ACCES | S LIMIT: | | | | | | |
|---------------------------------|--------------------------|--------------|------------------------------------|------------------------------|-------------------------|----------|------------------|--|
| √ 1% of Be * 3% choic | | able for Ber | ☐ 2% of nefit Bank amo | Benefit Bank unts greater | | | of Benefit Ba | nk* |
| ır initial Moı | nthly Benefit | t Access Lin | nit dollar amou | | <u>,000</u> fit Bank | | x <u>1</u> % = | \$_750 Monthly Benefit |
| NEY-BACK | | | romise Option | | | age. | | , 22 |
| | | | s for a refund o e holding your | | | | (less benefits p | oaid) to a beneficiary of yo |
| | | | primary and is named, any | • | | , | | ceive such a refund, if ar your estate. |
| Primar | y Beneficia | y 🗹 🤇 | Check here if th | nis is your Sp | ouse or | Domesti | c Partner | |
| ☐ Mr. | . • | Mrs. | ☐ Ms. | ☐ Dr | | | | |
| Jane | | | | | Doe | | | |
| Name | (First) | | | (MI) | (Last) | | | (Suffix) |
| Wife | | | | | | | | |
| Relatio | nship | | | | | | | |
| 1004 | <u>Main Street</u> | | | | _ | | | |
| | | | | | | Apt # | | |
| | Address | | | | | | | |
| Street A | | | <u>ST</u> | | _ | | 12345 | |
| Street A Anytow City | vn | . 5 | Sto | ate | _ | · · | Zip Code | |
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| Street A Anytow City | vn gent Benefic | iary 🗹 🤇 | Sto Check here if th | ate nis is your Sp | | Domesti | Zip Code | |
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| Anytow City Conting Mr. Name | gent Benefic . (First) | | Sto Check here if th | ate nis is your Sp Dr | · | Domestic | Zip Code | (Suffix) |

| the ben | IAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare efits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options and 3% Automatic Compound Inflation Protection. My choice is as follows: |
|--------------|--|
| | I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature. |
| | I elect Automatic 5% Compound Inflation Protection. |
| | I elect Automatic 3% Compound Inflation Protection. |
| OPTION | IAL LAPSE PROTECTION BENEFIT: |
| \checkmark | Yes. I elect to have the Lapse Protection Benefit as part of my coverage. |
| | No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit. |
| PREMIU | M PAYMENT OPTIONS: |
| | Lifetime Payment Option |
| | 10-Year Premium Payment Option* |
| | To-Age-65 Premium Payment Option* |
| | * These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection |

Section E: Premium Payment Authorization

| C <u>omple</u> | this section to authorize your preferred premium payment method. |
|----------------|--|
| | AUTOMATIC PAYROLL DEDUCTION (applicable only for participating employers) By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll. Payroll System/Division: |
| | DIRECT-BILLING (MAIL) Select one billing frequency: □ annually ☑ semi-annually □ quarterly □ monthly (\$2.00 monthly fee applicable) OR |
| | MONTHLY ELECTRONIC FUNDS TRANSFER How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium. |
| | Monthly Electronic Funds Transfer Agreement: I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason. |
| | Name of Bank: |
| | Bank Address: |
| | Telephone #: |
| | Account Type: |
| | Routing #: |
| | OR |

| AUTOMATIC CREDIT (| CARD PAYMENT | | | |
|----------------------|--------------|---------------|---------------------|------------------|
| Select Card Type: | [Visa] | [MasterCard] | [American Express] | [Discover Card] |
| Credit Card #: | | | | |
| Name as it appears o | on Card: | | | |
| Expiration Date: | | | | |

| Section F: Pers | sonal Physic | ian I | nformat | ion | |
|---|---|-----------|-----------------|----------------------|------------------|
| Please provide the following in (i.e., the physician with most of | | ersonal p | hysician, somet | imes called your Pri | mary Care Doctor |
| James | | | Smith | | |
| Physician's Name (First) | | (MI) | (Last) | | (Suffix) |
| 5689 First Street | | | 500 | | |
| Street Address | | | Suite # | | |
| Anytown | <u>ST</u> | | <u>123</u> | 45 | <u></u> |
| City | State | | Zip | Code | |
| 810-256-8956 | | | | | |
| Office Phone Number | | | | | |
| Have you seen this physician i | n the last two vears? | | ✓ Yes | ∏ No | |
| Date of last visit: 01/2009 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | — · · · | |
| month/y | year | | | | |
| • | • | | | | |
| Reason for visit: | | | | | |
| Annual Physical | | | | | |
| | | | | | |
| | | | | | _ |
| | | | | | |

| Sec | Section G: Medical History | | | | | | |
|-----|----------------------------|--------------|--|--|--|--|--|
| | | | | | | | |
| 1. | | | st 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a professional for any of the following conditions (check all that apply or NONE OF THE ABOVE). | | | | |
| | $\overline{\checkmark}$ | 1. | Drug or Alcohol Abuse | | | | |
| | | 2. | Disorders of Vision or Speech | | | | |
| | | 3. | Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease | | | | |
| | | 4. | Heart Attack, Angioplasty or Heart Surgery | | | | |
| | | 5. | Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery | | | | |
| | | 6. | Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker | | | | |
| | | 7. | Aneurysm, Peripheral Vascular Disease (PVD) | | | | |
| | | 8. | Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis | | | | |
| | | 9. | Fainting Spells or Blacking Out, Seizures, Epilepsy | | | | |
| | | 10. | Tremor, Myasthenia Gravis | | | | |
| | | 11. | Paralysis (partial or full), Post Polio Syndrome | | | | |
| | | 12. | Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma | | | | |
| | | 13. | Depression, Schizophrenia, or other forms of Mental Illness | | | | |
| | | 14. | Diabetes, Disease of the Pancreas or other glands | | | | |
| | | 15. | Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease | | | | |
| | | 16. | Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement | | | | |
| | | 1 <i>7</i> . | Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone | | | | |
| | | 18. | Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease | | | | |
| | | NON | NE OF THE ABOVE | | | | |

| lumber | Dates From/To | Physician's Name/Address/Phone | Describe | |
|--------------|--|--|-------------------------|------|
| 1 | 01/1985 to 01/2006 | James Smith, Anytown, ST 12345 810-256-8956 | Prescription Drug Abuse | |
| | | | | |
| ang If " | | you had any symptoms or knowledge of in that is not disclosed above? | √ Yes | □No |
| | he past 3 years, have | | | |
| | he <i>past 3 years,</i> have | | ✓ Yes | □ No |
| . In t | he <i>past 3 years,</i> have | you: | ✓ Yes Reason | □ No |
| In t | he <i>past 3 years,</i> have taken any prescr | you: iption medications (if "Yes", please list)? | _ | □ No |
| . In 1 a. | he <i>past 3 years,</i> have taken any prescr Medication | you: ription medications (if "Yes", please list)? Dosage | Reason | |
| In 1 | he <i>past 3 years,</i> have taken any prescr Medication | you: ription medications (if "Yes", please list)? Dosage | Reason | □ No |

| c. | | been treated for any reas IER THAN your Primary C t? | • | √ Yes | ☐ No | | |
|----------|---|--|--|--------------|---------|--|--|
| | If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates. | | | | | | |
| | Name | City & State | Specialty | Reason(s) | Dates | | |
| | Dave Jones | Anytown, ST | Gastro Interology | Acid Reflux | 01/2000 | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| ł. | • | a healthcare professional or a surgery that has not | • | √ Yes | □ No | | |
| d. | evaluation testing | or a surgery that has not explain type, reason and s g or surgery. | been performed? | √ Yes | □ No | | |
| d. €. | evaluation testing If "Yes", please e evaluation, testing Endoscopy, Not s | or a surgery that has not explain type, reason and s g or surgery. | been performed? cheduled date of the ansportation, | ✓ Yes ✓ Yes | □ No | | |

| 9(| ction H: Applicar | nt Profil | е | | | |
|----|--|------------------------|--------------------|-------------------|------------------|-------------|
| | | | | | | |
| | Please provide your height <u>6 f</u> t | | _ | | | |
| | In the <i>past 3 years</i> , have you u | sed any form c | of tobacco or nico | tine product? | ∀ Yes | ☐ No |
| | Date last used | | List types | of tobacco or nic | otine products u | sed |
| | 05/18/2009 | | Cigarette | | | |
| | | | | | | |
| | Do you work 20 or more hours | | • | | √ Yes | □ No |
| | If "Yes", please list your occupa | ation: <u>Financia</u> | <u>l Analysist</u> | | | |
| | Do you drive an automobile? | | | | ☐ Yes | ☑ No |
| | If "Yes", please provide approx | cimate annual i | mileage: | miles | | |
| | With whom do you live? | alone | √ spouse | ☐ family | other | |
| | Do you live in some form of a r If "Yes", please list the specific (e.g., housekeeping, laundry, n | services that ye | • | } | ✓ Yes | □ No |
| | Driving, Laundry | | | | | |
| | | | _ | | | |
| | In the past 3 years, have you h | ad any nursing | y home or long tei | rm care | ✓ Yes | □ No |
| | insurance application denied? If "Yes", by which company? | | | | | |
| | MetLife | | | | | |

Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

| Please | check one of the following: | | | | | | | | |
|---------------|---|-------------------------|-----------------------|----------|--|--|--|--|--|
| | I elect NOT to designate another person to receive this notice. | | | | | | | | |
| V | I elect to designate another person to receive this notice. | | | | | | | | |
| Comple | ete the information below ON | LY if you elect to name | an authorized person. | | | | | | |
| Jane | | | Doe | | | | | | |
| Name | (First) | (MI) | (Last) | (Suffix) | | | | | |
| 1234 <i>l</i> | Main Street | | | | | | | | |
| Street A | Address | | Apt # | | | | | | |
| Anytov | /n | ST | <u>12345</u> | | | | | | |
| City | | State | Zip Code | | | | | | |
| 810-23 | 35-6598 | | | | | | | | |
| Phone | Number | | | | | | | | |

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

| 1. | Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? | ✓ Yes | □ No |
|----|---|--------------|-------------|
| | If "Yes", provide details: | | |
| | Company Name: John Handcock | | |
| | Individual or Group Policy Number: 012562356 | | |
| | Type of Coverage: Long Term Care | | |
| 2. | Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? | √ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | If that policy lapsed, when did it lapse? 01/2008 | | |
| 3. | Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? | √ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | Company Address: 1245 Granger, Anytown, ST 12345 | | |
| | -OR- | | |
| | Individual or Group Policy Number: 0152365 | | |
| 4. | Are you currently covered by Medicaid? (not a reference to Medicare) | √ Yes | □ N∘ |

Section [H] [K]: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau P.O. Box 105, Essex Station Boston, Massachusetts 02111 866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company 10559 Citation Drive, Suite 300 Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an Application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an Application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing false, incomplete, or misleading information is guilty of a felony.

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
 I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- ☑ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE. I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: <u>05/02/2009</u> I certify that I have read, or have had read to me, the competed Application. Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy. I understand that I, or my authorized representative, may request to receive a copy of this authorization. Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above. **▼** ACCEPT ☐ DECLINE **Date:** 05/18/2009 I certify that I have signed the Application in: Anytown, ST City, State The applicant must sign the Application by voice authorization code entry or by signature via faxed Application. Please indicate the method of signature below: **Voice Authorization Code** 052365 ☐ Signature Via Faxed Application

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

| Clicking "Accept | represents my acknowledgement and under | standing of all statements above. |
|-------------------|---|-----------------------------------|
| ✓ ACCEPT | ☐ DECLINE | |
| Applicant's Voice | e Authorization Code: 052365 | Date: 05/18/2009 |

Section [K] [N]: Agent's Report, Certification and Signature

| How l | ong have you known the applicant? | | |
|-------|--|--------------|------|
| 1. | Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? | ✓ Yes | ☐ No |
| | If "No", please provide details in the "Remarks" section below. | | |
| 2. | Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? | ✓ Yes | □ No |
| | If "Yes", please provide details in the "Remarks" section below. | | |
| 3. | Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? | ✓ Yes | □ No |
| | If "Yes", please provide details in the "Remarks" section below. | | |
| 4. | Please list other health insurance policies sold by you to the applicant: N/A | | |
| 5. | Please list other health insurance policies sold by you to the applicant in the last fir force. John Hancock Long Term Care | | _ |
| | | | |
| 6. | Please list all policies that the applicant has in force: MetLife | | |
| | | | |
| 7. | Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? | √ Yes | □ No |
| | Remarks He is a smoker and has a bad Hand Tremor. | | |
| | | | |

| 8 | Policyholder Sales Agent (Select Agent Name in Case Split Information section on next page, if applicable.) If sent to the Policyholder, please select an address: | | | | | | | | | |
|-------------------------|---|----------------|--------------|------------------------|------------------------|---|--|--|--|--|
| | | | | | | | | | | |
| | | | | | | ✓ Policyholder Home Address (listed in Section B) | | | | |
| | | | | | | ☐ New Shipping Address: | | | | |
| | | Name (First) | (MI) | | ast) | (Suffix) | | | | |
| | | Street Address | | Apt # | | | | | | |
| City | | State | | Zip Code | | | | | | |
| | Phone Number | | | | | | | | | |
| V | I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this Application. I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance. | | | | | | | | | |
| | I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet. | | | | | | | | | |
| | (THE BOX BELOW ONLY IF TH TO REPLACE ANOTHER COVE | | | | CATION THAT HE/SHE | | | | | |
| $\overline{\checkmark}$ | I acknowledge that I have pro Accident and Sickness or Long | | ne Notice to | Applicant Regarding Re | placement of Individua | | | | | |
| Martin | | | | Long | | | | | | |
| Solicitii | ng Agent's Name (First) | | (MI) | (Last) | | | | | | |
| 0000001 | | | | 1256892222 | | | | | | |
| LifeSecure ID # | | | | Agent License # | | | | | | |
| 00000 | 0123 | | | 05/18/2009 | | | | | | |
| Contract # | | | | Date | | | | | | |

| Case S _I | olit Information (if applicable) | |
|---------------------|--|-----------------------------|
| Check | one box for Agent to receive Welcome Kit | |
| \checkmark | Agent Name <u>Martin Long</u> | % Split <u>100</u> |
| | Agent License # 1256892222 | Contract #: <u>00000123</u> |
| | LifeSecure ID # <u>00000001</u> | |
| | Agent Name | % Split |
| | Agent License # | Contract #: |
| | LifeSecure ID # | |
| | Agent Name | % Split |
| | Agent License # | Contract #: |
| | LifeSecure ID # | |
| | | 100% |

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

100%

Clicking "Accept" represents my acknowledgement, acceptance and authorization for all statements above.

✓ ACCEPT ☐ DECLINE





| Application | | | | | |
|----------------------|---|---|-----|----------|----|
| Application Status | | | Ne | yt. | |
| About LifeSecure | LTC Application: Section A B C D E F G H I J K L M | | | | |
| About Long Term Care | Section A: Personal Health History | | | | |
| About Our Product | Within the past 12 months, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of | | Yes | 0 | No |
| Quote Calculator | Long Term Care Facility? Or, within the <i>past 12 months</i> , have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? | | | | |
| Resource Center | 2. Do you <i>currently</i> use any of the following: | | Yes | © | No |
| | Walker Wheelchair Quad Cane Motorized scooter Hospital bed Oxygen equipment Dialysis | | | | |
| | 3. Do you currently require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? | C | Yes | O | No |
| | 4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: | | Yes | 0 | No |
| | Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease) Systemic Lupus Disease Alzheimer's Disease Dementia/Senility Mental Retardation Psychosis Stroke (CVA) within past 5 years Multiple Sclerosis (MS) Muscular Dystrophy Parkinson's Disease Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test Metastatic Cancer Type I (Juvenile) Diabetes Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day A Transient Ischemic Attack (TIA) within past 2 years, or multiple TIAs within past 5 years Chronic Kidney/Renal Disease Huntington's Chorea Cirrhosis of the Liver Organ Transplant Amputation due to Disease (not accident) | n | | | |
| | | | | © | No |





| og Out Hello, | | |
|------------------------|---|---|
| | _ | |
| Application | _ | |
| Application Status | LTC Application: Section A B C D E F | G H I J K L M |
| About LifeSecure | Section B: Applicant Information | |
| About Long Term Care | Employer/Group Name: ABC Company | |
| About Our Product | Group Number: 00001 | |
| About Our Product | Check ONLY one box below: | |
| Quote Calculator | I, the applicant, am: | |
| Resource Center | named above. I am actively-at-work, which mon the last regularly scheduled workday before | [25] [30] or more hours per week for the employer neans I was working at my usual place of employment e I completed this application. |
| | My date of hire was: 01/01/2005 | |
| | month/year | ampleyee of the ampleyer named above |
| | a spouse or domestic partner of an eligible His/her date of hire was: | employee of the employer hamed above. |
| | month/year | |
| | a family member of an eligible emp | oloyee, or a retiree/spouse , or a part-time ss than [15] [20] [25] [30] hours per week), of the |
| | John Doe Name (First) (MI) (Last) 1234 Mian Street Street Address | (Suffix) |
| | Apt. # | |
| | Anytown ST City State | Zip Code |
| | 01 / 01 / 1954 123 | 56 _ 7756 |
| | Date of Birth (mm/dd/yyyy) Social Secur | rity # OR Tax Identification # |
| | Gender: Marital Status | |
| | | Married Domestic Partner |
| | 810 _ 659 _ 2356 | 810 _ 235 _ 6593 |
| | Work Phone Number | Home Phone Number |
| | Best Time to Call: 9 a.m. 5 p.m. | Best Place to Call: Work Home |
| | JOHND@YAHOO.COM | JOHND@YAHOO.COM |
| | E-mail Address | Verify E-mail Address |
| | Employee Number (if applicable) | |





| Log Out Hello, | | | | |
|----------------------|---------------------------------|---------------------------------|--|---------------------|
| Application | _ | | | |
| Application Status | 1 Please select your Hee | r Name and Password Voulle | use these to log onto the Policyh | oldors Portal after |
| About LifeSecure | your policy is approve | d. You'll also use your user na | ime and password to log back of you decide to save it and finish | onto the Group & |
| About Long Term Care | | st contain at least one number. | naracters long and can contain | only letters and |
| About Our Product | User Name | jandj Password | Confirm Password | |
| Quote Calculator | | | ect answer to the question. We will enable you to select a new p | |
| Resource Center | What was your first pet? | | | |
| | Security Question Dog | | | |
| | Security Answer | | | |
| | | | | Reset Next |





| Log Out Hello, | | | | |
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| Application | | | | |
| Application Status | LTC Application: Section A B C D E F G H I J K L M | | | Next |
| About LifeSecure | Section C: Spouse or Domestic Partner Information | | | |
| About Long Term Care | PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SE | OUSE OR DO | OMESTIC PA | .RTNER IS |
| About Our Product | — APPLYING. You may qualify for a couple's discount. | | | |
| Quote Calculator | ☐ Mr. ☐ Mrs. ☐ Dr. Jane Doe | | | |
| Resource Center | Name (First) (MI) (Last) | | (Suffix) | |
| | | | | |
| | Is your spouse or domestic partner also applying for coverage? | C Yes | ⓒ No | |
| | | | | |
| | | | | |
| | s | ave Reset | Previous | Next |





| out LifeSecure out Cong Term Care out Our Product source Center | BENEFIT BA Enter a dollar MONTHLY B 1% of * 3% ch Your initial M MONEY-BAC Yes, I This cobenefit Please enter any. | E Coverage ANK: r amount between the second available of the second availabl | ween \$ EESS L lable for the Mefit prochoice for a printing is | ection 75,000 IMIT: | s and \$1,000,0 6 of Benefit E t Bank amoun dollar amoun ck Promise O or a refund hould die whi d a continger any applicabl | 00 \$75,000 ank ank ts greater tha | 3% of Be n \$500,000 X f my covera ge of prer policy for ! who should | _1_% = age. miums (less 5 or more y I receive su your estate. | \$750 Monthly Benefi s benefits pears. | | |
|--|--|--|--|--|--|--|---|--|--|--|--|
| out LifeSecure out Long Term Care out Our Product ote Calculator source Center | Section Date of the sectio | E Coverage ANK: r amount between the second available of the second availabl | ween \$ EESS L lable for the Mefit prochoice for a printing is | ection 75,000 IMIT: | and \$1,000,0 6 of Benefit E t Bank amount dollar amount ck Promise O or a refund hould die whi d a continger any applicabl here if this is Dr. Doe | ank ants greater than straight spending spart of a percentalle holding your at beneficiary serefund will be a serefund will be | 3% of Be n \$500,000 X f my covera ge of prer policy for ! who should | enefit Bank ³). _1_% = age. miums (less or more y large receive surpour estate. | * \$750 Monthly Benefits pears. Ich a refunc | | |
| out Our Product ote Calculator source Center | BENEFIT BA Enter a dollar MONTHLY B 1% of * 3% ch Your initial M MONEY-BAC Yes, I This control benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | RANK: r amount between a sene of the name | ween \$ EESS L lable for the Mefit procedure choice a printiary is | IMIT: 29 or Benefits Limit ON: oney-Bactovides for if yours somey and the control of the contr | and \$1,000,0 6 of Benefit E t Bank amount dollar amount ck Promise O or a refund hould die whi d a continger any applicabl here if this is Dr. | ank st greater tha st \$75,000 Benefit Bank ption as part of a percentale holding your at beneficiary to the refund will be | f my coverage of prer policy for should a made to y | o). _1_% = age. miums (lesson to the second to the seco | \$750 Monthly Benefits pears. Ich a refund | | |
| ote Calculator ource Center | MONTHLY B 1% of * 3% ch Your initial M MONEY-BAC Yes, I This control benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | BENEFIT ACC BENEFIT ACC Benefit Bank noice not avail CK PROMISE elect to have optional beneficiary of your the name of If no benefici neficiary Mrs. | t Acces the Mefit prochoice a printiary is | IMIT: 29 or Benefits Services Limit ON: oney-Bacterian Services of the servi | 6 of Benefit E t Bank amount dollar amount ck Promise O or a refund hould die whi d a continger any applicabl here if this is Doe | ank st greater tha st \$75,000 Benefit Bank ption as part of a percentale holding your at beneficiary to the refund will be | f my coverage of prer policy for should a made to y | o). _1_% = age. miums (lesson to the second to the seco | \$750 Monthly Benefits pears. Ich a refund | | |
| ource Center | MONTHLY B 1% of * 3% ch Your initial M MONEY-BAC Yes, I This control benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | BENEFIT ACC f Benefit Bank noice not avail lonthly Benefi CK PROMISE elect to have optional beneficiary of your the name of If no benefici neficiary Mrs. | t Acces the Mefit prochoice a printiary is | IMIT: 29 or Benefits Services Limit ON: oney-Bacterian Services of the servi | 6 of Benefit E t Bank amount dollar amount ck Promise O or a refund hould die whi d a continger any applicabl here if this is Doe | ank st greater tha st \$75,000 Benefit Bank ption as part of a percentale holding your at beneficiary to the refund will be | f my coverage of prer policy for should a made to y | o). _1_% = age. miums (lesson to the second to the seco | \$750 Monthly Benefits pears. Ich a refund | | |
| ource Center | * 3% ch * 3% ch Your initial M MONEY-BAC Yes, I This control benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | f Benefit Bank noice not avail lonthly Beneficiary of your the name of the noice optional beneficiary of your the name of the Mrs. | t Acces OPTI the M efit pro choice a prir iary is | or Beneficss Limit ON: oney-Bacterian servides of if you servides and mary and marked, Check Ms. | t Bank amound dollar amound ck Promise Of a refund hould die which a continger any applicable here if this is the Doe | sts greater that \$75,000 Benefit Bank ption as part of a percentate holding your at beneficiary to the refund will be | f my coverage of prer policy for should a made to y | o). _1_% = age. miums (lesson to the second to the seco | \$750 Monthly Benefits pears. Ich a refund | | |
| | * 3% ch Your initial M MONEY-BAC Yes, I This control benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | noice not avail lonthly Benefick PROMISE elect to have optional beneficiary of your the name of If no beneficiary | t Acces OPTICE the Mefit prochoice a printiary is | or Benefics Limit ON: oney-Bactovides for if you some and | t Bank amound dollar amound ck Promise Of a refund hould die which a continger any applicable here if this is the Doe | sts greater that \$75,000 Benefit Bank ption as part of a percentate holding your at beneficiary to the refund will be | f my coverage of prer policy for should a made to y | o). _1_% = age. miums (lesson to the second to the seco | \$750 Monthly Benefits pears. Ich a refund | | |
| | MONEY-BAC Yes, I This obenefic Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | elect to have optional beneficiary of your the name of If no beneficiary Mrs. | option the Merit process of a principal princi | ON: oney-Ba ovides f if you s mary an named, Check Ms. | ck Promise O or a refund hould die whi d a continger any applicabl here if this is Doe | Benefit Bank ption as part o of a percenta le holding your nt beneficiary e refund will be | f my coverage of prerepolicy for should a made to ye | age. miums (less 5 or more y I receive su your estate. | Monthly Benefits pears. | | |
| | This of benefit Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | elect to have optional beneiciary of your the name of If no beneficiary Mrs. | e the Mefit procedure for a printing is | oney-Ba ovides f if you s mary an named, Check Ms. | or a refund hould die whi d a continger any applicable here if this is to the Doe | of a percentalle holding your not beneficiary to refund will be | ge of prer policy for s who should made to y | miums (less 5 or more y I receive su your estate. | ears. | | |
| | This obenefic Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | optional beneiciary of your the name of If no beneficiary Mrs. | efit procent of the choice of a print is | ovides f if you s mary an named, Check Ms. | or a refund hould die whi d a continger any applicable here if this is to the Doe | of a percentalle holding your not beneficiary to refund will be | ge of prer policy for s who should made to y | miums (less 5 or more y I receive su your estate. | ears. | | |
| | Please enter any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | iciary of your the name of If no beneficiary The mediciary The Mrs. | choice a prir iary is | if you s mary an named, Check Ms. | hould die whi d a continger any applicabl here if this is C Dr. Doe | le holding your It beneficiary The refund will be | policy for swho should made to y | 5 or more y I receive su your estate. | ears. | | |
| | any. Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | If no benefici neficiary Mrs. | iary is ⊽ | named, Check Ms. | any applicabl here if this is Dr. | e refund will be | e made to y | our estate. | | | |
| | Please Note: Primary Ber Mr. Jane Name (First) Wife Relationship | neficiary Mrs. | ~ | Check Ms. | here if this is Doe | | _ | | (Suffix) | | |
| | Jane Name (First) Wife Relationship | Mrs. | | Ms. | Doe | s your Spouse | or Domestic | c Partner | (Suffix) | | |
| | Jane Name (First) Wife Relationship | | | | Doe | | | | (Suffix) | | |
| | Name (First) Wife Relationship | | | (MI) | J | | | | (Suffix) | | |
| | Wife Relationship | | | (IVII) | (Last) | | | | (Suffix) | | |
| | | -4 | | | | | | | | | |
| | 1234 Main Stree | | Relationship | | | | | | | | |
| | Street Address | | | | | | | | | | |
| | Anytow n | | | | ST | w | | | | | |
| | City | | | | State | Zip C | ode | | | | |
| | Contingent | Donoficiony | | ▽ | acal bara if th | nis is your Spo | uss or Dom | ostis Dortne | ~r | | |
| | Contingent Mr. | Mrs. | | Ms. | Dr. | iis is your spo | use or Dom | iestic Pai trie | 2 1 | | |
| | IVII . | IVII 5. | | IVIS. | DI. | | | | | | |
| | Name (First) | | | (MI) | (Last) | | | | (Suffix) | | |
| | | | | | | | | | , , | | |
| | Relationship | | | | | | | | | | |
| | Street Address | S | | | | | | | | | |
| | | | | | | | | | | | |
| | City | | | | State | Zip C | ode | | | | |
| | No. I r | reject the Mor | ney-Ba | ck Prom | ise Option as | part of my cov | verage. | | | | |
| | graphs that protection. S Protection. M I reject will income. | compare the Specifically, I ly choice is as | e bene I have s follow atic Con arantee % Con | fits and e reviev vs: mpound ed Future npound | premiums of yed options Inflation Prote Purchase Of official official protession of the protession of | ection. | vith and w 3% Autom | vithout auto natic Comp | omatic infla oound Infla | | |
| | | i Automatic 3 | 70 CUIT | ιρουπα | ווומנוטוו 11016 | SCHOIT. | | | | | |





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| Application | |
| Application Status | OPTIONAL LAPSE PROTECTION BENEFIT: Yes. I elect to have the Lapse Protection Benefit as part of my coverage. |
| About LifeSecure | No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the polic with and without Lapse Protection benefits and I reject the Lapse Protection Benefit. |
| About Long Term Care | Premium Payment Options: Lifetime |
| About Our Product | Premium Payment Options. |
| Quote Calculator | Total Monthly Premium[**]: \$\frac{750}{100} = \frac{100}{100} = \f |
| Resource Center | reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.] |
| | Save Reset Previous Next |
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| Out Hello, oplication oplication Status out LifeSecure out Long Term Care out Our Product uote Calculator | LTC Application: Section A B C D E F G H I J K L M Section E: Premium Payment Authorization Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. Payroll System/Division: | Next |
|---|--|---|
| oplication Status oout LifeSecure oout Long Term Care oout Our Product | Section E: Premium Payment Authorization Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | |
| oplication Status oout LifeSecure oout Long Term Care oout Our Product | Section E: Premium Payment Authorization Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | |
| oout LifeSecure oout Long Term Care oout Our Product uote Calculator | Section E: Premium Payment Authorization Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | |
| oout Long Term Care oout Our Product uote Calculator | Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | n care insurance |
| oout Our Product note Calculator | Complete this section to authorize your preferred premium payment method. AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | n care insurance |
| uote Calculator | AUTOMATIC PAYROLL DEDUCTION By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | ı care insurance |
| | By electing this payment method, I authorize my employer to deduct my long term premiums automatically from my payroll. | n care insurance |
| | | |
| source Center | rayidii Systeiii/Divisidii. | |
| | Payroll Location: | |
| | Payroll Frequency: | |
| | Employee Number: | |
| | | |
| | DIRECT BILLING (MAIL) | |
| | Select billing frequency: | |
| | annually semi-annually quarterly monthly (\$2.00 monthly) | y fee applicable) |
| | MONTHLY ELECTRONIC FUNDS TRANSFER | |
| | offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will term care insurance premiums from your bank account electronically. You do not need to mail in any payments. Premium withdrawals will appear on your bank statement, and will be your receipts for payment of your premium. Monthly Electronic Funds Transfer Agreement: I authorize LifeSecure to electronically withdraw money from my account for the paymer for this insurance policy. I authorize LifeSecure to continue to make these withdraw renewal, or other change in the policy. I will compensate LifeSecure for any loss, or caused by these withdrawals and will not hold LifeSecure responsible for any such loss, or This authorization will not affect the terms of the policy. Authorizing this automatic paynot put the insurance policy into effect. This authorization may be retracted by me or L time for any reason by giving written notice. LifeSecure may retract the authorizati without giving me written Notice, if any debt is not paid by the bank stated below, for any Name of Bank: Bank Address: Telephone #: Account Type: | ent of premiums rals if there is a claim, or liability yment plan does lifeSecure at any ion immediately, |
| | | |
| | AUTOMATIC CREDIT CARD PAYMENT | |
| | Select Card Type: [Visa] [MasterCard] [American Express] [Di | iscover Card] |
| | Credit Card #: (do not enter dashes or space | es) |
| | Name as it appears on Card: | |
| | Expiration Date: / | |
| | Name as it appears on Card: | , |





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| Application | | | |
| Application Status | LTC Application: Section A B C D E <u>F</u> G H I J K L M | | Next |
| About LifeSecure | Section F: Personal Physician Information | | |
| About Long Term Care | Please provide the following information about your personal physician, so | | your |
| About Our Product | Primary Care Doctor (i.e., the physician with most of your medical records) |). | _ |
| Quote Calculator | James Smith Physician's Name (First) (MI) (Last) | (Suffix) | |
| Resource Center | 5689 First Street | | |
| | Street Address | | |
| | 500 | | |
| | Suite # | | |
| | Anytow n ST | | |
| | City State Zip Code | | |
| | | | |
| | 810 _ 256 _ 8956 | | |
| | Office Phone Number | | |
| | Have you seen this physician in the last two years? Yes No | | |
| | Date of last visit: 01 / 2009 | | |
| | month year | | |
| | Reason for visit: | | |
| | Annual Physical | | |
| | ▼ ▼ | | |
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| Application | | |
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| Application Status | | Next |
| About LifeSecure | LTC Application: Section A B C D E F G H I J K L M | Next |
| About Long Term Care | Section G: Medical History (Part 1) | |
| About Our Product | 1. In the past 3 years, have you received medical advice or treatment, been diagnomentation consulted with a healthcare professional for any of the following conditions (check all the NONE OF THE ABOVE). | |
| Quote Calculator | | |
| | 1. Drug or Alcohol Abuse | |
| Resource Center | 2. Disorders of Vision or Speech | |
| | 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease | |
| | 4. Heart Attack, Angioplasty or Heart Surgery | |
| | 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery | |
| | 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker | |
| | 7. Aneurysm, Peripheral Vascular Disease (PVD) | |
| | 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bro | onchitis |
| | 9. Fainting Spells or Blacking Out, Seizures, Epilepsy | |
| | 10. Tremor, Myasthenia Gravis | |
| | 11. Paralysis (partial or full), Post Polio Syndrome | |
| | lacksquare 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple My | eloma |
| | \square 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness | |
| | 14. Diabetes, Disease of the Pancreas or other glands | |
| | \square 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Dis | sease |
| | lacksquare 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement | |
| | \square 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone | |
| | ☐ 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease | |
| | NONE OF THE ABOVE | |
| | | |
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Application

Application Status

About LifeSecure

About Long Term Care

About Our Product

Quote Calculator

Resource Center

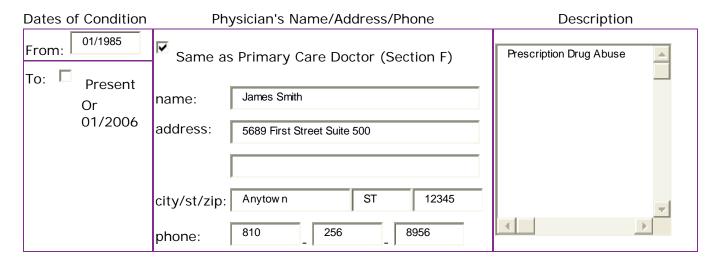
LTC Application: Section A B C D E F G H I J K L M

Next

Section G: Medical History (Part 2)

Please give details below to all boxes checked in Question #1 of this section.

1. Drug or Alcohol Abuse



Save Reset Previous Next





| og Out Hello, | | |
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| Application | | |
| Application Status | LTC Application: Section A B C D E F G H I J K L M | Next |
| About LifeSecure | Section G: Medical History (Part 3) | |
| About Long Term Care | | |
| About Our Product | 2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Please describe: | C Yes C No |
| Quote Calculator | Acid Reflux | |
| Resource Center | 3. In the <i>past 3 years</i> , have you: | |
| | | c _{Yes} c _{No} |
| | Medication Dosage Reason X Nexium 50 mg Acid Reflux | |
| | Medication Dosage Reason | |
| | Nexium 50 mg Acid Reflux | |
| | | |
| | | |
| | Add b. been confined in or advised to enter a hospital or rehabilitation facility? | E _{Yes} C _{No} |
| | Please explain and include dates and reasons: | Yes No |
| | 01/1986 Rehab Clinic for Prescription Drug abuse | |
| | c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates. | C Yes C No |
| | Name/Location/Specialty Reason Consulted Dates | |
| | Dave Jones/ Anytown, ST/ Gastro Interology Acid Reflux 01/2000 | |
| | Dave Jones/ Anytown, ST/ Ga A Acid Reflux | |
| | Add | |
| | d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? | c _{Yes} c _{No} |
| | Please explain type, reason and scheduled date of the evaluation, testing or surgery: | |
| | Endoscopy, Not Scheduled | |
| | e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? | C Yes C No |
| | Please explain and include dates and reasons: Can't Drive | |
| | | |
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| pplication | | |
| oplication Status | LTC Application: Section A B C D E F G <u>H</u> I J K L M | Nex |
| out LifeSecure | | |
| out Long Term Care | Section H: Applicant Profile | |
| out Our Product | 1. Please provide your height 6 ft. 2 in., and weight 250 lbs. | |
| ote Calculator | 2. In the <i>past 3 years</i> , have you used any form of tobacco or nicotine product? Yes | □ _{No} |
| source Center | Date Last Used Types of Tobacco or Nicotine Products Used | |
| | O5/18/2009 Cigarettes | |
| | | |
| | 05/18/2009 Cigarettes | |
| | | |
| | Add | |
| | 3. Do you work 20 or more hours a week outside your home? Yes | |
| | Please list your occupation: | 140 |
| | 4. Do you drive an automobile? Yes | ⊙ No |
| | Please provide approximate annual mileage: miles 5. With whom do you live? | |
| | alone spouse family other | |
| | 6. Do you live in some form of a residential retirement community? Yes | |
| | Please list the specific services that you are receiving (e.g., housekeeping, laundry, meals): | 140 |
| | Driving, Laundry | |
| | | |
| | 7. In the past 3 years, have you had any nursing home or long term care insurance application denied? Yes | □ _{No} |
| | By which company? MetLife | |
| | IVELLIE | |
| | Save Reset Previous | ıs Ne |





| Log Out Hello, | | |
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| Application | | |
| Application Status | LTC Application: Section A B C D E F G H I J K L M | Next |
| About LifeSecure | Section [F] [I]: Protection Against Unintended Lapse or Term | nination |
| About Long Term Care | I understand that I have the right to designate at least one authorized person, ot | |
| About Our Product | notice of lapse or termination of this long term care coverage due to nonpayment that notice will not be given to this person until 30 days after a premium is due and Please check one of the following: | |
| Quote Calculator | ■ I elect NOT to designate another person to receive this Notice. | |
| Resource Center | I elect to designate another person to receive this Notice. | |
| | Complete the information below ONLY if you elect to name an authorized person. Jane Doe Name (First) (MI) (Last) | (Suffix) |
| | 1234 Main Street Street Address | |
| | Apt. # | |
| | Anytow n ST | |
| | City State Zip Code | |

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

LS-0205 ST 08/09 Reset Previous Next

810

Phone Number

235

6598





Yes No

Next

Previous

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| Log Out Hello, | |
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| Application | |
| Аррисасіон | <u> </u> |
| Application Status | LTC Application: Section A B C D E F G H I J K L M |
| About LifeSecure | Section [G] [J]: Replacement Inquiry |
| About Long Term Care | Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered. |
| About Our Product | |
| Quote Calculator | Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization Yes No contract)? |
| Resource Center | Please provide the following details: |
| | Company Name: John Handcock |
| | Individual or Group Policy Number: 012562356 |
| | Type of Coverage: Long Term Care |
| | 2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? Yes No |
| | With which company? MetLife |
| | If that policy lapsed, when did it lapse? 01/2008 |
| | 3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? If "Yes", provide details: Company Name: MetLife Company Address: 1245 Granger, Anytown, ST 12345 OR- |
| | Individual or Group Policy Number: 0152365 |

4. Are you currently covered by Medicaid? (not a reference to Medicare)





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Application

Application Status

About LifeSecure

About Long Term Care

About Our Product

Quote Calculator

Resource Center

doce calculator

LTC Application: Section A B C D E F G H I J K L M

Next

Section [H] [K]: Other Notices to Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a Non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau P.O. Box 105, Essex Station Boston, Massachusetts 02111 866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company 10559 Citation Drive, Suite 300 Brighton, MI 48116

in fo@Your Life Secure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

To residents of **Kentucky**: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.



Resource Center



| Log Out Hello, | |
|----------------------|---|
| | |
| Application | |
| Application Status | |
| About LifeSecure | To residents of New Mexico : Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. |
| About Long Term Care | To the residents of Oklahoma : WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading |
| About Our Product | information is guilty of a felony. |
| Quote Calculator | Save Reset Previous Next |
| | LS-0205 ST 08/09 |





| Log Out Hello, |
|----------------------|
| |
| Application |
| Application Status |
| About LifeSecure |
| About Long Term Care |
| About Our Product |
| Quote Calculator |
| Resource Center |

LTC Application: Section A B C D E F G H I J K L M

Next

Section [I] [L]: Applicant Authorization and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ✓ I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section [H] [K] of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application.
 I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have No liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been No change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F] [I] of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- ▼ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

That particular notice was delivered to me on: 05 / 02 / 2009

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

| C ACCEPT DECLINE | Date | : 05 | / | 18 | / 20 | 09 | | | |
|--|------|----------|---|----|------|-----|-------|----------|------|
| I certify that I have signed the Application | ı in | Anytow n | | | | | ST | | |
| r dertily that i have signed the Application | | City | | | | | State | _ | |
| | | | | | Sa | ive | Reset | Previous | Next |
| LS-0205 ST 08/09 | | | | | | | | | |



Resource Center



Insurance Portability and

Next

| Log Out Hello, | |
|----------------------|--|
| Application | |
| Application Status | LTC Application: Section A B C D E F G H I J K L M |
| About LifeSecure | Section [J] [M]: Applicant Authorization to Obtain and Disclose Information |
| About Long Term Care | |
| About Our Product | This authorization is designed to satisfy the requirements of the Health Insurance Portability Accountability Act of 1996, as it may be amended from time to time (HIPAA). |
| Quote Calculator | By signing this authorization form, I agree to the following: |

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

| Clicking "Acc | ept" represents my | acknowledgeme | nt and | d und | erstand | ling | of all sta | tements ab | ove |
|---------------|--------------------|---------------|--------|-------|---------|------|------------|------------|-----|
| ACCEPT | DECLINE | Date: | 05 | / | 18 | _/ | 2009 | | |

Since your application responses require LifeSecure to obtain an "Attending Physician Statement" to complete the application approval process, LifeSecure must obtain a paper copy of an "Applicant Authorization to Obtain and Disclose Information", signed by you. This signed paper copy will acknowledge your approval for LifeSecure to request and obtain and "Attending Physician Statement" from your physician. Please click the box below if you would like a paper copy of the authorization form sent to you via a mail delivery system for signature. Or, for guicker service, please download, print and sign the form from this link "HIPAA form". Fax the signed form to 1-888-550-5424 and then mail the form with your signature to: LifeSecure Administrative Offices, 3050 Universal Blvd., Ste. 150, Weston, FL 33331. Thank you.

| | Save | Reset | Previous | Next |
|------------------|------|-------|----------|------|
| LC 000F CT 00/00 | | | | |





Log Out | Hello, |

Application

Application Status

About LifeSecure

About Long Term Care

About Our Product

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L M

Next

Coverage Summary

Premium Plan: [Lifetime Payment Option]

[10-Year Payment Option] [To-Age-65 Option]

| Benefit Bank Amount | [\$75,000 - \$1,000,0000] |
|------------------------------|------------------------------------|
| Monthly Benefit Access Limit | [\$XX,XXX] [(1%)] [(2%)] [(3%)] |
| Monthly Premium | [\$XXX.XX] |
| Benefit Wait Period | [90] calendar days |
| Other Benefits Included | |
| | |

| Previous | Submit Competed Application |
|----------|-----------------------------|
|----------|-----------------------------|

Section A: Personal Health History

| 1. | Within the past 12 months, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the past 12 months, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? | ☐ Yes | ☑ No |
|----|--|-------|-------------|
| 2. | Do you currently use any of the following: - Walker - Wheelchair - Quad Cane - Motorized scooter - Hospital bed - Oxygen equipment - Dialysis | ☐ Yes | ☑ No |
| 3. | Do you <i>currently</i> require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? | Yes | ☑ No |
| 4. | Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: | Yes | ☑ No |
| 5. | Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease) Systemic Lupus Disease Alzheimer's Disease Dementia/Senility Mental Retardation Psychosis Stroke (CVA) within past 5 years Multiple Sclerosis (MS) Muscular Dystrophy Parkinson's Disease Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test Metastatic Cancer Type I (Juvenile) Diabetes Diabetes - treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day A Transient Ischemic Attack (TIA) within past 2 years, or multiple TIAs within past 5 years Chronic Kidney/Renal Disease Huntington's Chorea Cirrhosis of the Liver Organ Transplant Amputation due to Disease (not accident) Are you currently receiving Social Security Disability benefits? | Yes | ✓ No |
| J. | | _ | |
| | If you answered " Yes " to any part of any question in Section A, PLEASE DO NOT CO We regret that we cannot offer you long term care insurance coverage. If your circumstances change, you may consider reapplying at a future time. | | |
| | If you answered "No" to all questions in Section A, please CONTINUE. | | |

Section B: Applicant Information

| Employer/Group Name: ABC Company | | Group Nu | mber: <u>00001</u> | |
|--|----------------------|----------------------|------------------------|---------------------|
| Check ONLY one box below: | | | | |
| I, the applicant, am: | | | | |
| | s I was working at m | y usual place of | employment on the last | regularly scheduled |
| a spouse or domestic partner of an His/her date of hire was: | | | | |
| a family member of an eligible em works less than [15] [20] [25] [30] | | | | se (who regularly |
| ☑ Mr. ☐ Mrs. ☐ Ms. | ☐ Dr. | | | |
| John (5) | | <u>Doe</u> | _ | <u> </u> |
| Name (First) | (MI) | (Last) | | (Suffix) |
| 1234 Main Street | | A t. # | | |
| Street Address | | Apt # | _ | |
| Anytown ST City Ste | ate | <u>1234</u> Zip C | <u> </u> | |
| , | uie | Zip C | oue | |
| 01/01/1954 Date of Birth (mm/dd/yyyy) | | | | |
| <u>123 - 56 - 7756</u> | | | | |
| Social Security Number | OR Tax la | lentification # | | |
| | | | | |
| Gender: | Martial Status: | | | |
| ☑ Male ☐ Female | ☐ Single | ✓ Married | ■ Domestic Partner | |
| 810-659-2356 | <u>810-235-659</u> ; | 3 | | |
| Work Phone Number | Home Phone N | Number | | |
| Best Time to Call: 9 a.m. 5 p.m. | | | | |
| Best Place to Call: ☑ Work ☐ Home | | | | |
| johnd@yahoo.com | | | | |
| E-mail Address | Employee Nur | nber (if applicab | le) | |

| 1. | approved. You'll also use your your application, should you c | r user name and password to log back lecide to save it and finish it later. The | g onto the Policyholders Portal after your policy i k onto the Groups & Associations Portal to comp e user name and password must be between 6 a word must contain at least one number. | lete |
|----|---|---|--|------|
| | johnd | jand j | jand j | |
| | User Name | Password | Confirm Password | |
| 2. | | Question and the correct answer to the wer will enable you to select a new po | e question. We will ask you this question if you fo assword. | rget |
| | What was you first pet? | | | |
| | Security Question | | | |
| | | | | |
| | Dog | | | |
| | Security Answer | | | |

Section C: Spouse Or Domestic Partner Information

| PLEASE COMPLETE You may qualify fo | | | HETHE | r or not your spouse or domestic | Partner is applying. |
|---------------------------------------|-----------------|---------------------|---------|----------------------------------|----------------------|
| ☐ Mr. ☑ | Mrs. | ☐ Ms. | Dr. | | |
| Jane | | | | Doe | |
| Name (First) | | | (MI) | (Last) | (Suffix) |
| 125 - 95 - | 1236 | | | - | |
| Social Security Nu | ımber | OR | | Tax Identification # | |
| Is your spouse or c | domestic partne | er also applying fo | r covei | rage? ☐ Yes ☑ No | |

Section D: Coverage Selections

| BENEFIT | BANK: Enter of | a dollar amount | between \$75 | ,000 and \$1 | ,000,00 | 00 <u>\$75</u> , | 000 | | |
|------------|--|------------------|------------------|--------------------------------|----------------|------------------|--------------------|-----------------------------|--|
| v 1 | ILY BENEFIT AC % of Benefit Ba % choice not a | | | Benefit Bank unts greater t | | | of Benefit Bank | * | |
| | · | nefit Access Lim | it dollar amou | | 000 it Bank | | x <u>1</u> % = \$_ | 750 Monthly Benefit | |
| MONEI | -BACK PROMISE OPTION: Yes. I elect the Money-Back Promise Option as part of my coverage. | | | | | | | | |
| | • | • | | • | • | | (less benefits pa | id) to a beneficiary of you | |
| | choice if you should die while holding your policy for 5 or more years. Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any Please note: If no beneficiary is named, any applicable refund (if any) will be made to your estate. | | | | | | | | |
| | Primary Benef | iciary 🗹 🤇 | Check here if th | is is your Sp | ouse or | Domestic | Partner | | |
| | ☐ Mr. | ✓ Mrs. | ☐ Ms. | ☐ Dr. | | | | | |
| | <u>Jane</u> | | | | Doe | | | | |
| | Name (First) | | | (MI) | (Last) | | | (Suffix) | |
| | Wife | | | | _ | | | | |
| | Relationship | | | | | | | | |
| | 1234 Main Street | | | | | | | _ | |
| | Street Address | | | | | Apt # | | | |
| | Anytown | | <u>ST</u> | | _ | | 12345 | | |
| | City | | | | | | Zip Code | | |
| | Contingent Ber | neficiary 🔲 🤇 | Check here it th | is is your Sp | ouse or | Domestic | Partner | | |
| | ☐ Mr. | ☐ Mrs. | ☐ Ms. | ☐ Dr. | | | | | |
| | Name (First) | | | (MI) | (Last) | | | (Suffix) | |
| | Relationship | | | | | | | | |
| | Street Address | | | | | Apt # | | | |
| | City | | Stc | ıte | | _ | Zip Code | | |
| | No. I reject the | e Money-Back F | Promise Option | as part of m | ny cover | age. | | | |

| the ben | IAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare efits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options and 3% Automatic Compound Inflation Protection. My choice is as follows: |
|--------------|---|
| | I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature. |
| | I elect Automatic 5% Compound Inflation Protection. |
| | I elect Automatic 3% Compound Inflation Protection. |
| OPTION | NAL LAPSE PROTECTION BENEFIT: |
| \checkmark | Yes. I elect to have the Lapse Protection Benefit as part of my coverage. |
| | No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit. |
| PREMIU | M PAYMENT OPTIONS: |
| \checkmark | Lifetime Payment Option |
| | 10-Year Premium Payment Option* |
| | To-Age-65 Premium Payment Option* |
| | * These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage. |
| [** If | onthly Premium[**]: \$_750 the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Aonthly Premium represents the full amount of monthly premium that is required to keep your policy in force.] |

Section E: Premium Payment Authorization

| omple | ete this section to authorize your preferred premium payment method. |
|-------|--|
| | AUTOMATIC PAYROLL DEDUCTION (applicable only for participating employers) |
| | By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll. Payroll System/Division: |
| | Payroll Location: |
| | Payroll Frequency: |
| | Employee Number: |
| | |
| V | DIRECT-BILLING (MAIL) |
| | Select one billing frequency: |
| | ☐ annually ☑ semi-annually ☐ quarterly ☐ monthly (\$2.00 monthly fee applicable) |
| | OR |
| _ | MONTHLY ELECTRONIC FUNDS TRANSFER |
| | How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium. Monthly Electronic Funds Transfer Agreement: I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms |
| | of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason. |
| | Name of Bank: |
| | Bank Address: |
| | Telephone #: |
| | Account Type: |
| | Routing #: |
| | OR |
| | |
| | |
| | |

| AUTOMATIC CREDIT C Select Card Type: | CARD PAYMENT | [MasterCard] | [American Express] | [Discover Card] |
|--|--------------|---------------|---------------------|------------------|
| Credit Card #: Name as it appears o Expiration Date: | | | | - |

| Please provide the following in (i.e., the physician with most o | | sonal p | hysician, somet | times called your Pr | imary Care Doctor |
|--|-----------------------|---------|-----------------------|----------------------|-------------------|
| <u>James</u> | | | Smith | | 10.5% |
| Physician's Name (First) | (. | MI) | (Last) | | (Suffix) |
| 5689 First Street Street Address | | | <u>500</u> Suite # | | |
| Anytown | ST | | 123 | 345 | |
| City | State | | Zip | Code | |
| 810-256-8956 Office Phone Number | | | | | |
| Have you seen this physician i | n the last two years? | | ✓ Yes | □ No | |
| Date of last visit: <u>01/2009</u> month/ | year | | | | |
| Reason for visit: | | | | | |
| Annual Physical | | | | | |

| Sec | tio | n G | 6: Medical History |
|-----|--------------|-------------------------|--|
| | | | |
| 1. | In th | ne <i>pa:</i> thcare | st 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a professional for any of the following conditions (check all that apply or NONE OF THE ABOVE). |
| | \checkmark | 1. | Drug or Alcohol Abuse |
| | | 2. | Disorders of Vision or Speech |
| | | 3. | Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease |
| | | 4. | Heart Attack, Angioplasty or Heart Surgery |
| | | 5. | Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery |
| | | 6. | Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker |
| | | 7. | Aneurysm, Peripheral Vascular Disease (PVD) |
| | | 8. | Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis |
| | | 9. | Fainting Spells or Blacking Out, Seizures, Epilepsy |
| | | 10. | Tremor, Myasthenia Gravis |
| | | 11. | Paralysis (partial or full), Post Polio Syndrome |
| | | 12. | Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma |
| | | 13. | Depression, Schizophrenia, or other forms of Mental Illness |
| | | 14. | Diabetes, Disease of the Pancreas or other glands |
| | | 15. | Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease |
| | | 16. | Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement |
| | | 1 <i>7</i> . | Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone |
| | | 18. | Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease |
| | | | NONE OF THE ABOVE |

| Number | Dates From/To | Physician's Name/Address/Phone | Describe | |
|------------------------------|--|---|----------------------------|------|
| 01 | 01/1985 to 01/2006 | James Smith, Anytown, ST 12345 810-256-8956 | Prescription Drug Abuse | |
| | | | | |
| | | | | |
| | he <i>past 3 years,</i> have | | | |
| If "' <u>Ac</u> | y other health condition Yes", please describe Lid Reflux he past 3 years, have | | √ Yes | |
| If "' <u>Ac</u> . In t | y other health condition Yes", please describe Lid Reflux he past 3 years, have | you: ription medications (if "Yes", please list)? | | □ No |
| If "' Ac In t | y other health condition Yes", please describen Cid Reflux The past 3 years, have taken any prescri | you: | √ Yes | □ No |
| If " Ac In t | y other health condition Yes", please describential Sid Reflux The past 3 years, haventaken any prescri | you: ription medications (if "Yes", please list)? Dosage | √ Yes Reason | □ No |
| If " Ac In t | y other health condition Yes", please describential Sid Reflux The past 3 years, haventaken any prescri | you: ription medications (if "Yes", please list)? Dosage | √ Yes Reason | □ No |
| If " Ac In t | y other health condition Yes", please describe Lid Reflux The past 3 years, have taken any prescri Medication Nexium | you: ription medications (if "Yes", please list)? Dosage | ✓ Yes Reason Acid Reflux | □ No |

| c. | consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? | √ Yes | ☐ No |
|----|---|--------------|---------|
| | If "Yes", please provide the Healthcare Professional's name, loca specialty, reason consulted and dates. | tion, | |
| | Name/Location/Specialty | Reason(s) | Dates |
| | Dave Jones, Anytown, ST, Gastro Interology | Acid Reflux | 01/2000 |
| | | | |
| | | | |
| | | | |
| d. | been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? | ✓ Yes | ☐ No |
| | If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery. Endoscopy, Not Scheduled | | |
| e. | required assistance with shopping, using transportation, | √ Yes | □ No |
| | housekeeping, cooking or taking medications? | _ | _ |
| | If "Yes", please explain and include dates and reasons. | | |

| Please provide your height <u>6 ft 2 in</u> (ft. & ir | n.) and weight 250 (lbs.) | | | |
|--|------------------------------|------------------|-------------|--|
| In the past 3 years, have you used any form | - | √ Yes | □ No | |
| Date last used List types of tobacco or nicotine products used | | | | |
| Date last used | List types of tobacco or nic | otine products u | sed | |
| 05/18/2009 | Cigarette | | | |
| | | | | |
| Do you work 20 or more hours a week outside | • | ✓ Yes | □ No | |
| If "Yes", please list your occupation: Financia | al Analysist | | | |
| Do you drive an automobile? | | ☐ Yes | ☑ No | |
| If "Yes", please provide approximate annual | mileage: miles | | | |
| With whom do you live? | ☑ spouse ☐ family | other | | |
| Do you live in some form of a residential retin | • | ✓ Yes | □ No | |
| If "Yes", please list the specific services that y (e.g., housekeeping, laundry, meals). | you are receiving | | | |
| Driving, Laundry | | | | |
| | | | | |
| In the past 3 years, have you had any nursin | g home or long term care | √ Yes | □ No | |
| insurance application denied? If "Yes", by which company? | | | | |
| MetLife | | | | |

Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

| Please check one of the follow | ving: | | | |
|--------------------------------|-----------------------|--------------|-----------------------|----------|
| ☐ I elect NOT to design | nate another person t | o receive t | his notice. | |
| ✓ I elect to designate o | nother person to rece | eive this no | otice. | |
| Complete the information bel | ow ONLY if you elec | t to name o | an authorized person. | |
| Jane | | | Doe | |
| Name (First) | | (MI) | (Last) | (Suffix) |
| 1234 Main Street | | | | |
| Street Address | | | Apt # | |
| Anytown | <u>ST</u> | | 12345 | |
| City | State | | Zip Code | |
| 810-235-6598 | | | | |
| Phone Number | | | | |
| | | | | |

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

| 1. | Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? | √ Yes | □ No |
|----|---|--------------|-------------|
| | If "Yes", provide details: | | |
| | Company Name: John Handcock | | |
| | Individual or Group Policy Number: 012562356 | | |
| | Type of Coverage: Long Term Care | | |
| 2. | Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? | √ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | If that policy lapsed, when did it lapse? 01/2008 | | |
| 3. | Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? | √ Yes | □ No |
| | If "Yes", provide details: | | |
| | Company Name: MetLife | | |
| | Company Address: 1245 Granger, Anytown, ST 12345 | | |
| | -OR- | | |
| | Individual or Group Policy Number: 0152365 | | |
| 4. | Are you currently covered by Medicaid? (not a reference to Medicare) | √ Yes | □ N∘ |

Section [H] [K]: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau P.O. Box 105, Essex Station Boston, Massachusetts 02111 866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company 10559 Citation Drive, Suite 300 Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an Application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an Application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing false, incomplete, or misleading information is guilty of a felony.

LS-0205 ST 08/09

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and A Shopper's Guide to Long Term Care Insurance.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
 I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

LS-0205 ST 08/09 18

REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on:

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

ACCEPT DECLINE Date: 05/18/2009

I certify that I have signed the Application in: Anytown, ST

City, State

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO

LS-0205 ST 08/09

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

| Clicking "Acce | pt" represents my o | acknowledgement an | d understand | ling of a | ll statements a | bove. |
|-----------------|---------------------|--------------------|-------------------|-----------|-----------------|-------|
| ✓ ACCEPT | ☐ DECLINE | Date | : <u>05/18/20</u> | 09 | | |

Since your application responses require LifeSecure to obtain an "Attending Physician Statement" to complete the application approval process, LifeSecure must obtain a paper copy of an "Applicant Authorization to Obtain and Disclose Information", signed by you. This signed paper copy will acknowledge your approval for LifeSecure to request and obtain and "Attending Physician Statement" from your physician. Please click the box below if you would like a paper copy of the authorization form sent to you via a mail delivery system for signature. Or, for quicker service, please download, print and sign the form from this link "HIPAA form". Fax the signed form to 1-888-550-5424 and then mail the form with your signature to: LifeSecure Administrative Offices, 3050 Universal Blvd., Ste. 150, Weston, FL 33331. Thank you.

LS-0205 ST 08/09 20



LifeSecure Insurance Company

10559 Citation Drive, Suite 300 Brighton, MI 48116

SCHEDULE OF BENEFITS

Policyholder: [John Smith Policy Number: [LS-0000001]

10 Main Street

Anytown, USA 11111] Policy Effective Date: [05/01/07]

Age At Issue: [45] [Coverage Change

Effective Date: 07/01/10]

BENEFITS AND COVERAGE AMOUNTS

Benefit Bank: [\$75,000 - \$1,000,000]

Monthly Benefit Access Limit: [1%, 2% or 3% of Benefit Bank] [(\$###)]

[Guaranteed Future Purchase Offers: Included]
[Contingent Non-Forfeiture Benefit: Included]

Benefit Wait Period: [30, 60, 90, 100, 120 or 180] Calendar Days

[OPTIONAL BENEFITS ELECTED]

[Money-Back Promise Option Included]
[Automatic 3% Compound Inflation Protection Benefit: Included]
[Automatic 5% Compound Inflation Protection Benefit: Included]
[Lapse Protection Benefit: Included]

PREMIUM INFORMATION

Premium Rate Classification: [Preferred, Standard, Select, Multi-Life]
Premium Payment Mode: [Monthly, Quarterly, Semi-annual, Annual]

Premium Payment Time Period: [Lifetime, 10-years, To-age-65]

[Marital Discount Applied:10%][Dual Spouse Coverage Discount Applied:20%][Endorsed Association Discount Applied:5%, 10%][Employer Contribution Discount:5%]

Premium Amount[*]: [\$###] per [month, quarter, semi-annual period,

year,]

[\$### per payroll deduction]

[*The premium amount includes the premium contribution, if any, paid by an employer sponsor.]

LS-0051 ST 08/09 Schedule of Benefits Print Date: [05/24/07]

SERFF Tracking Number: LFSC-126136721 State: Arkansas State Tracking Number: 42479

Filing Company: LifeSecure Insurance Company

Company Tracking Number:

TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number:

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LFSC-126136721 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 42479

Company Tracking Number:

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: Multi-Life Application Filing

Project Name/Number:

Supporting Document Schedules

Review Status:

Bypassed -Name: Flesch Certification 05/01/2009

Bypass Reason: Applications only

Comments:

Review Status:

Bypassed -Name: Application 05/01/2009

Bypass Reason: attached in the forms tabs

Comments:

Review Status:

Satisfied -Name: Health - Actuarial Justification 05/01/2009

Comments: Attachment:

ACTMEM-Nationwide-MultiLife_Addendum_052009.pdf

Review Status:

Bypassed -Name: Outline of Coverage 05/01/2009

Bypass Reason: N/A - only filing applications, not replacing our currently approved Outline of Coverage

Comments:

Review Status:

Satisfied -Name: Explanation of Variability 05/26/2009

Comments: Attachment:

Explanation of Variability.pdf

LifeSecure Insurance Company Long Term Care Policy Form LS-0002 Addendum to Actuarial Memorandum

I. PURPOSE OF THIS FILING

The purpose of this actuarial addendum is to add the following rate classes to the original premiums filed:

- 1) A discounted set of rates for sales to individuals in employer groups, where the employee is paying his own premium. These rates are discounted 1% off the standard LS-0002 premiums.
- 2) A 5% additional discount will be applied to the rates from #1 for sales to individuals in employer groups, where the employer is contributing to the premium.
- 3) A discounted set of rates for sales to members of associations. These rates are discounted 5% off the rate class LS-0002 premiums.

II. GROUP DISCOUNT

At the discretion of the company, sales may be made to individuals in groups of policyholders that are list billed or marketed together, due to being part of an employer group, or to members of an association. For these multi-life sales, the attached discounted premiums will be used. Simplified underwriting may be used in the employer setting, based on group size and participation level. For association sales, agent compensation will be reduced.

III. ASSUMPTIONS

Relatively modest assumption changes were made, compared to base policy assumptions, as summarized below:

- Selection factors were increased for simplified underwriting (except for associations, which will use full underwriting),
- Commission rates were decreased for associations,
- Underwriting expenses were reduced for simplified underwriting,
- Voluntary lapse rates were increased for employer paid groups.

IV. CERTIFICATION

The certification of the original actuarial memorandum is not affected by the addition of these premium classes.

Davn E. Helising

Dawn E. Helwig, F.S.A., M.A.A. Member, American Academy of Actuaries May 20, 2009



LifeSecure Insurance Company Annual Long Term Care Premiums - Policy Form LS-0002 90 Day Elimination Period; Daily Benefit = \$100 Single Premiums; Sales to Individuals in Employer Groups*

Employee Pay Base Premiums** Monthly Payment, as % of Benefit Bank:

| Monthly Payment, as % of Benefit Bank: | | | | | | |
|--|----------------|----------------|----------------|--|--|--|
| Issue Age | 1% | 2% | 3% | | | |
| issue Age | (8.3 year BP) | (4.2 year BP) | (2.8 year BP) | | | |
| | (c.c year Dr) | 1112 your Di j | (E.O your D.) | | | |
| 30 and under | \$434 | \$393 | \$358 | | | |
| 31 | 445 | 402 | 365 | | | |
| 32 | 454 | 411 | 373 | | | |
| 33 | 465 | 420 | 380 | | | |
| 34 | 476 | 429 | 387 | | | |
| 35 | 487 | 438 | 395 | | | |
| 36 | 498 | 446 | 402 | | | |
| 37 | 509 | 455 | 409 | | | |
| 38 | 524 | 467 | 420 | | | |
| 39 | 539 | 480 | 430 | | | |
| 40 | 553 | 493 | 440 | | | |
| 41 | 568 | 505 | 450 | | | |
| 42 | 583 | 518 | 460 | | | |
| 43 | 602 | 534 | 474 | | | |
| 44 | 621 | 549 | 487 | | | |
| 45 | 640 | 565 | 500 | | | |
| 46 | 658 | 581 | 514 | | | |
| 47 | 676 | 597 | 527 | | | |
| 48 | 704 | 620 | 546 | | | |
| 49 | 731 | 643 | 565 | | | |
| 50 | 757 | 665 | 584 | | | |
| 51 | 784 | 688 | 604 | | | |
| 52 | 811 | 712 | 623 | | | |
| 53 54 | 843 876 | 740 767 | 646 670 | | | |
| 55 | 908 | 767 794 | 693 | | | |
| 56 | 941 | 822 | 717 | | | |
| 57 | 972 | 849 | 740 | | | |
| 58 | 1,056 | 923 | 802 | | | |
| 59 | 1,139 | 995 | 864 | | | |
| 60 | 1,224 | 1,067 | 926 | | | |
| 61 | 1,308 | 1,139 | 988 | | | |
| 62 | 1,391 | 1,212 | 1,049 | | | |
| 63 64 | 1,519 1,645 | 1,322 1,433 | 1,144 1,239 | | | |
| 65 | 1,772 | 1,542 | 1,335 | | | |
| 66 | 1,900 | 1,653 | 1,430 | | | |
| 67 | 2,027 | 1,763 | 1,524 | | | |
| 68 | 2,387 | 2,073 | 1,788 | | | |
| 69 | 2,746 | 2,382 | 2,051 | | | |
| 70 | 3,107 | 2,692 | 2,315 | | | |
| 71 | 3,466 | 3,001 | 2,578 | | | |
| 72 73 | 3,826 4,491 | 3,311 3,880 | 2,841 3,322 | | | |
| 74 | 5,154 | 4,449 | 3,803 | | | |
| 75 | 5,818 | 5,018 | 4,284 | | | |
| 76 | 6,483 | 5,588 | 4,765 | | | |
| 77 | 7,146 | 6,157 | 5,246 | | | |
| 78 | 7,378 | 6,376 | 5,441 | | | |
| 79 | 7,610 | 6,593 | 5,636 | | | |
| 80 | 7,843 | 6,811 | 5,832 | | | |
| 81 82 | 8,074 8,307 | 7,030 7,248 | 6,027 6,222 | | | |
| 83 | 8,714 | 7,246 7,619 | 6,542 | | | |
| 84 | 9,121 | 7,991 | 6,861 | | | |
| 04 | 0,121 | .,501 | 0,001 | | | |

| Adjustment Factors | | | | | |
|--------------------|---|--|--|--|--|
| Marital Discount: | 30% if both purchase. (Multiply Single Rates by 0.70) 10% if only one purchases (Multiply Single Rates by 0.90) | | | | |

^{**} Employer Pay Factor: Apply 5% discount if employer contributes to premium.

^{*} Applicability of multi-life rates are subject to certain group size and participation requirements.

LifeSecure Insurance Company Annual Long Term Care Premiums- Policy Form LS-0002 90 Day Elimination Period; Daily Benefit = \$100 Single, Standard Premiums; Sales to Individuals in Associations

Base Premiums

| | Base Premiums | | | | | |
|--------------|--|----------------|----------------|--|--|--|
| | Monthly Payment, as % of Benefit Bank: | | | | | |
| Issue Age | 1% | 2% | 3% | | | |
| | (8.3 year BP) | (4.2 year BP) | (2.8 year BP) | | | |
| | | **** | *** | | | |
| 30 and under | \$416 | \$377 | \$344 | | | |
| 31 | 427 | 386 | 351 | | | |
| 32 | 436 | 394 | 358 | | | |
| 33 | 447 | 403 | 365 | | | |
| 34 | 457 | 411 | 371 | | | |
| 35 | 467 | 420 | 379 | | | |
| 36 | 478 | 428 | 386 | | | |
| 37 | 488 | 437 | 392 | | | |
| 38 | 503 | 448 | 403 | | | |
| 39 | 517 | 461 | 412 | | | |
| 40 | 531 | 473 | 422 | | | |
| 41 | 545 | 485 | 432 | | | |
| 42 | 560 | 497 | 442 | | | |
| 43 | 578 | 512 | 455 | | | |
| 44 | 596 | 527 | 467 | | | |
| 45 | 614 | 542 | 480 | | | |
| 46 | 632 | 558 | 493 | | | |
| 47 | 649 | 573 | 505 | | | |
| 48 | 675 | 595 | 524 | | | |
| 49 | 701 | 617 | 542 | | | |
| 50 | 727 | 638 | 561 | | | |
| 51 | 752 | 660 | 580 | | | |
| 52 | 778 | 683 | 598 | | | |
| 53 | 809 | 710 | 620 | | | |
| 54 | 841 | 736 | 643 | | | |
| 55 56 | 871 903 | 762 789 | 665 688 | | | |
| 57 | 933 | 815 | 710 | | | |
| 58 | 1,014 | 885 | 770 | | | |
| 59 | 1,093 | 955 | 829 | | | |
| 60 | 1,174 | 1,024 | 888 | | | |
| 61 | 1,255 | 1,093 | 948 | | | |
| 62 | 1,335 | 1,163 | 1,007 | | | |
| 63 | 1,457 | 1,268 | 1,098 | | | |
| 64 | 1,579 | 1,375 | 1,189 | | | |
| 65 | 1,701 | 1,480 | 1,281 | | | |
| 66 67 | 1,823 1,945 | 1,587 1,692 | 1,372 1,462 | | | |
| 68 | 2,290 | 1,989 | 1,716 | | | |
| 69 | 2,635 | 2,286 | 1,968 | | | |
| 70 | 2,981 | 2,583 | 2,221 | | | |
| 71 | 3,326 | 2,879 | 2,474 | | | |
| 72 | 3,672 | 3,177 | 2,727 | | | |
| 73 | 4,309 | 3,723 | 3,188 | | | |
| 74 | 4,946 | 4,269 | 3,649 | | | |
| 75 | 5,583 | 4,816 | 4,111 | | | |
| 76 77 | 6,221 | 5,362 | 4,572 | | | |
| 77 78 | 6,857 7,080 | 5,908 6,118 | 5,034 5,221 | | | |
| 76 79 | 7,080 | 6,327 | 5,408 | | | |
| 80 | 7,526 | 6,536 | 5,596 | | | |
| 81 | 7,748 | 6,746 | 5,784 | | | |
| 82 | 7,971 | 6,955 | 5,971 | | | |
| 83 | 8,362 | 7,311 | 6,278 | | | |
| 84 | 8,752 | 7,668 | 6,584 | | | |
| | | | | | | |

30% if both purchase. (Multiply Single Rates by 0.70) 10% if only one purchases (Multiply Single Rates by 0.90) Marital Discount:

Multiply Standard Rates by 0.90 Multiply Standard Rates by 1.4 Preferred Rates: Substandard Rates:

Explanation of Variability:

INDIVIDUAL LONG TERM CARE INSURANCE SCHEDULE OF BENEFITS (LS-0051 ST 08/09)

- The data fields for Policyholder, Policy Number, Policy Effective Date and Age At Issue are populated with sample data. Real applicant data will appear at issue.
- The Coverage Change Effective Date entry and its data field will appear only if there has been a coverage change at a future date from the Policy Effective Date.
- The data field for the Benefit Bank amount will be populated with the selected amount.
- The data field for the Monthly Benefit Access Limit will be populated with the selected percentage of Benefit Bank and the resulting dollar amount.
- Guaranteed Future Purchase Offers will appear with "Included" in its data field, only if it applies to the individual's coverage. (It will apply as standard, unless the individual elected one of the two optional automatic inflation protection benefits.) If it does not apply, neither the benefit nor the data field will appear.
- Contingent Non-Forfeiture Benefit will appear with "Included" in its data field, only if it applies to the individual's coverage. (It will apply as standard, unless the individual elected the optional Lapse Protection Benefit.) If it does not apply, neither the benefit nor the data field will appear.
- The data field for the Benefit Wait Period will be populated with the appropriate number of days.
- The Money-Back Promise Benefit will appear in the Optional Benefits Elected with "Included" in the data field, only if elected.
- Automatic 3% Compound Inflation Protection Benefit will appear, and "Included" will appear in its data field, only if it applies to the individual's coverage. If it does not apply, neither the benefit nor the data field will appear.
- Automatic 5% Compound Inflation Protection Benefit will appear, and "Included" will appear in its data field, only if it applies to the individual's coverage. If it does not apply, neither the benefit nor the data field will appear.
- Lapse Protection Benefit will appear, and "Included" will appear in its data field, only if it applies
 to the individual's coverage. If it does not apply, neither the benefit nor the data field will
 appear.
- The applicable Premium Rate Classification will appear at issue in the data field.
- The applicable Premium Payment Mode will appear in that term's data field.
- The applicable Premium Payment Time Period will appear in that term's data field.
- The applicable Base Policy Coverage Modal Premium will appear in the term's data field.
- The premium discount amount will appear in the data field for the Married Discount, Dual Spouse Coverage Discount and Endorsed Group Discount only if applicable to the individual's coverage.
- The Employer Contribution Discount will only appear of the Premium Rate Classification is MultiLife and is applicable to the individual's coverage.

- The modal premium amount for the Policyholder will appear in the data field for the Money-Back Promise Benefit (if optional), Automatic 3% Compound Inflation Protection Modal Premium, Automatic 5% Compound Inflation Protection Modal Premium, Lapse Protection Benefit Modal Premium. The entries and data fields will appear only if they apply to the individual's coverage.
- The asterisk next to the Premium Amount entry and the corresponding note below will appear only if the premium amount includes a premium contribution from a group sponsor.
- The actual dollar total for the Premium Amount and the applicable premium payment mode will appear at time of issue.
- The data field section of the Schedule of Benefits Print Date is illustrative and will be populated with a real date at issue.

Long Term Care Applications (LS-0204 ST 08/09 & LS-0205 ST 08/09)

Section B:

• The Minimum Hours (15, 20, 25, 30) will be chosen during design. They will be the only options that will be given.

Section D:

• The Benefit Bank Amount \$400,000 is the maximum limit to receive Simplified Issue Qualification, the sponsor of the organization or employer will choose this amount during the plan setup. . The amount could be anywhere between \$75,000 and \$400,000. The issue ages for use of the Simplified Issue is 18 to 68. Persons 68 through 84 will complete the full application.

Section E:

• The credit card types are bracketed so that we may in the future offer Discover or American Express as payment options.

Sections F, G & H

- These sections are bracketed because if an applicant meets the Simplified Issue Qualifications these sections will not be completed and in the electronic versions will be suppressed and the applicant will not see the screens. If they do not meet the qualifications, these screens will appear and require the applicant to complete them.
- Section title (I),(J), (K), (L), (M), (N), (O) are bracketed so that if Sections F,G,H will not appear the section letters will follow in a correct alpha order.